



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 5/1/2026. 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](https://www.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 Orenzia
- Continued for six months after HSCT
- Used in combination with both of the following:
  - calcineurin inhibitor (e.g., cyclosporine, tacrolimus)
  - methotrexate

<b>Age Restrictions</b>	<b>aGVHD:</b> 2 years of age or older
<b>Prescriber Restrictions</b>	<b>RA, PJIA:</b> Prescribed by or in consultation with a rheumatologist <b>PsA:</b> Prescribed by or in consultation with a dermatologist or rheumatologist
<b>Coverage Duration</b>	<b>RA, PJIA, PsA: Initial:</b> 6 months. <b>Renewal:</b> 12 months <b>aGVHD: Initial:</b> 2 months. <b>Renewal:</b> N/A
<b>Renewal Criteria</b>	Documented positive clinical response to therapy  <b>RA, PJIA:</b> 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

<b>Required Medical Information</b>	<b>Diagnosed with severe psoriasis</b> <ul style="list-style-type: none"><li>• Patient is unresponsive to at least 2 conventional therapies (topical corticosteroids, vitamin D analogs, Tazorac, topical tacrolimus, Elidel, phototherapy).</li></ul>
<b>Age Restrictions</b>	Females of childbearing age <b>AND</b> able to bear children must comply with ALL the following: <ul style="list-style-type: none"><li>• 2 negative urine or serum pregnancy tests prior to therapy</li><li>• commit to using 2 effective forms of birth control starting 1 month prior to acitretin treatment monthly pregnancy tests during therapy</li></ul>
<b>Prescriber Restrictions</b>	Prescribed by a dermatologist.
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<b>Renewal Criteria:</b> Documentation of continued effectiveness. <b>Renewal Criteria</b> for females able to bear children: Documentation of required pregnancy monitoring <b>AND</b> continued effectiveness.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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

<b>Required Medical Information</b>	<p><b>Rheumatoid arthritis (RA)</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of moderately to severely active RA <b>AND</b> trial and failure, contraindication, or intolerance to one non-biologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)].</li> </ul> <p><b>Polyarticular Juvenile idiopathic arthritis (PJIA)</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of moderate to severely active polyarticular JIA</li> <li>• Trial and failure, contraindication, or intolerance to one of the following non-biologic disease-modifying antirheumatic drugs (DMARDs)             <ul style="list-style-type: none"> <li>○ Arava (leflunomide)</li> <li>○ Methotrexate (Rheumatrex/Trexall).</li> </ul> </li> </ul> <p><b>Psoriatic arthritis (PsA)</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of active PsA with one of the following             <ul style="list-style-type: none"> <li>○ actively inflamed joints</li> <li>○ dactylitis</li> <li>○ enthesitis</li> <li>○ axial disease</li> <li>○ active skin and/or nail involvement.</li> </ul> </li> </ul>
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## 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

	<p>topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar.</p> <p><b>Hidradenitis Suppurativa (HS):</b> Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)</p> <p><b>Uveitis (UV):</b> Diagnosis of non-infectious uveitis <b>AND</b> uveitis is classified as one of the following: intermediate, posterior or panuveitis.</p>
<p><b>Age Restrictions</b></p>	
<p><b>Prescriber Restrictions</b></p>	<p><b>RA, PJIA, AS:</b> Prescribed by or in consultation with a rheumatologist</p> <p><b>PsA:</b> Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist.</p> <p><b>CD, UC:</b> Prescribed by or in consultation with a gastroenterologist</p> <p><b>PsO, HS:</b> Prescribed by or in consultation with a dermatologist</p> <p><b>UV:</b> Prescribed by or in consultation with one of the following: ophthalmologist or rheumatologist</p>
<p><b>Coverage Duration</b></p>	<p><b>RA, PJIA, PsA, PsO, AS, CD, HS, UV Initial:</b> 6 months; <b>Renewal:</b> 12 months</p> <p><b>UC: Initial:</b> 12 weeks; <b>Renewal:</b> 12 months</p>
<p><b>Renewal Criteria</b></p>	<p><b>RA, PJIA:</b> 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.</p> <p><b>PsA:</b> 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.</p> <p><b>AS:</b> 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.</p> <p><b>CD:</b> 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,</p>

## 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

- Vioice TAB

## Prior Authorization Criteria

### Criteria Details

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

# Apremilast (OTEZLA)

## Products Affected

- Otezla
- Otezla XR

## Prior Authorization Criteria

### Criteria Details

<p><b>Required Medical Information</b></p>	<p><b>Plaque Psoriasis (PsO):</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of plaque psoriasis</li> <li>• Trial and failure of a minimum duration of a 30-day trial, contraindication, or intolerance to one of the following topical therapies:             <ul style="list-style-type: none"> <li>○ Corticosteroids (e.g. betamethasone, clobetasol)</li> <li>○ Vitamin D analogs (e.g. calcitriol, calcipotriene)</li> <li>○ Tazarotene</li> <li>○ Calcineurin inhibitors (e.g. tacrolimus, pimecrolimus)</li> </ul> </li> </ul> <p><b>Psoriatic Arthritis (PsA):</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of active psoriatic arthritis with one of the following:             <ul style="list-style-type: none"> <li>○ Actively inflamed joints</li> <li>○ Dactylitis</li> <li>○ Enthesitis</li> <li>○ Axial disease</li> <li>○ Active skin and/or nail involvement</li> </ul> </li> </ul> <p><b>Oral Ulcers Associated with Behçet's Disease:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of Behçet's Disease</li> <li>• Patient has active oral ulcers</li> </ul>
<p><b>Age Restrictions</b></p>	<p>Age 6 or older</p>
<p><b>Prescriber Restrictions</b></p>	<p><b>Plaque psoriasis:</b> Prescribed by or in consultation with a dermatologist.  <b>Psoriatic arthritis:</b> Prescribed by or in consultation with a dermatologist or rheumatologist.</p>
<p><b>Coverage Duration</b></p>	<p><b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.</p>
<p><b>Renewal Criteria</b></p>	<p><b>Plaque Psoriasis (PsO):</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response to therapy as evidenced by one of the following:</li> </ul>

## 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).

<b>Effective Date</b>	03/01/2026
<b>P&amp;T Approval Date</b>	01/11/2022
<b>P&amp;T Revision Date</b>	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

<b>Required Medical Information</b>	<b>Pulmonary tuberculosis</b> <ul style="list-style-type: none"><li>• Evidence of active pulmonary tuberculosis caused by mycobacterium tuberculosis that is resistant to at least rifampin and isoniazid.</li><li>• The member weighs at least 15kg.</li><li>• Sirturo is prescribed as part of a guideline recommended multi-drug treatment regimen.</li></ul>
<b>Exclusion Criteria</b>	Medication is being received through a county clinic with a state funded TB program.
<b>Age Restrictions</b>	5 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by Infectious Disease
<b>Coverage Duration</b>	<b>Pulmonary tuberculosis:</b> 24 weeks
<b>Renewal Criteria</b>	N/A
<b>Effective Date</b>	05/01/2025
<b>P&amp;T Approval Date</b>	03/11/2025
<b>P&amp;T Revision Date</b>	03/11/2025

# Bempedoic acid (NEXLETOL)

## Products Affected

- NEXLETOL TABLETS
- NEXLIZET TABLETS

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Established clinical ASCVD:</b></p> <ul style="list-style-type: none"> <li>• Documentation of very high risk ASCVD as evidenced by either:             <ul style="list-style-type: none"> <li>○ History of multiple major ASCVD events <b>OR</b></li> <li>○ One major ASCVD event <b>AND</b> multiple high-risk conditions.</li> </ul> </li> <li>• Documentation of a current LDL greater than or equal to 55 mg/dl.</li> <li>• Documentation that:             <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> <li>• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).</li> </ul> <p><b>Primary or familial hyperlipidemia:</b></p> <ul style="list-style-type: none"> <li>• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.</li> <li>• Documentation of current LDL greater than 100 mg/dL.</li> <li>• Documentation that:             <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> <li>• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).</li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

## Criteria Details

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

# Belumosudil (REZUROCK)

## Products Affected

- REZUROCK

## Prior Authorization Criteria

### Criteria Details

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

# Bicalutamide (CASODEX)

## Products Affected

- BICALUTAMIDE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	Metastatic prostate cancer prescribed in combination with a LHRH analogue.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by oncologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Brexipiprazole (REXULTI)

## Products Affected

- REXULTI

## Prior Authorization Criteria

### Criteria Details

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

# BUTRANS, BUPRENORPHINE PATCH, BELBUCA

## Products Affected

- BELBUCA
- BUPRENORPHINE PATCH

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Cancer or End-of-Life Care: Patient is being treated for cancer related pain or pain associated with end-of-life:</b> Documented trial and failure of, scheduled short-acting opioid therapy <b>AND</b> documented trial and failure or contraindication to long-acting morphine sulfate therapy. Documented trial/failure of, or reason why fentanyl is not appropriate.</p> <p><b>Other Chronic Pain:</b> 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 <b>AND</b> documented trial and failure or contraindication to short-acting opioid therapy <b>AND</b> documented trial and failure of, or contraindication to long-acting morphine sulfate therapy <b>AND</b> documented trial and failure of, or reason why fentanyl is not appropriate.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial cancer/end of life:</b> 12 months. <b>Initial non-cancer/end of life:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Cenegermin (Oxervate)

## Products Affected

- Oxervate Ophthalmic

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<ul style="list-style-type: none"><li>• Confirmed diagnosis of stage 2 or 3 neurotrophic keratitis</li><li>• Trial and failure of at least one ocular lubricant used for at least 2 weeks</li></ul>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist
<b>Coverage Duration</b>	<b>Initial:</b> 8 weeks. <b>Renewal:</b> N/A, no renewal allowed
<b>Effective Date</b>	11/01/2025
<b>P&amp;T Approval Date</b>	09/09/2025
<b>P&amp;T Revision Date</b>	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

	<p><b>Non-radiographic Axial Spondyloarthritis (nr-axSpA):</b> Diagnosis of active non-radiographic axial spondyloarthritis <b>AND</b> 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.) <b>AND</b> minimum duration of one month trial and failure, contraindication, or intolerance to two different NSAIDs (e.g., ibuprofen, naproxen) at maximally tolerated doses</p>
<p><b>Age Restrictions</b></p>	
<p><b>Prescriber Restrictions</b></p>	<p><b>CD:</b> Prescribed by or in consultation with a gastroenterologist  <b>RA, AS, nr-axSpA:</b> Prescribed by or in consultation with a rheumatologist  <b>PsA:</b> Prescribed by or in consultation with one of the following:  Dermatologist or Rheumatologist  <b>PsO:</b> Prescribed by or in consultation with a dermatologist</p>
<p><b>Coverage Duration</b></p>	<p><b>CD: Initial:</b> 16 weeks; <b>Renewal:</b> 12months  <b>RA, PsA, AS, PsO, nr-axSpA: Initial:</b> 6 months; <b>Renewal:</b> 12 months</p>
<p><b>Renewal Criteria</b></p>	<p><b>CD:</b> 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.</p> <p><b>RA:</b> 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.</p> <p><b>PsA:</b> 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.</p> <p><b>AS, nr-axSpA:</b> 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</p>

## 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

<b>Required Medical Information</b>	<b>Lennox-Gastaut Syndrome</b> <ul style="list-style-type: none"><li>• Confirmed diagnosis.</li></ul> <b>Refractory Seizures</b> <ul style="list-style-type: none"><li>• Documentation showing appropriate trial of 2 or more tolerated anticonvulsant therapies.</li></ul>
<b>Age Restrictions</b>	<b>Solution only</b> One of the following: <ul style="list-style-type: none"><li>• Pediatric member age 10 or under</li><li>• Documentation inability of the member to use the preferred tablet formulation</li></ul>
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> Lifetime.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	5/1/2025
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	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

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Continuous Glucose Monitor (CGM)

## Products Affected

- DEXCOM G6 & G7 SYSTEMS
- FREESTYLE LIBRE SYSTEMS

### Prior Authorization Criteria

## Criteria Details

<b>Required Medical Information</b>	<p>Patient has documented diagnosis of type 1 or type 2 diabetes mellitus. Patient must have ALL of the following:</p> <ul style="list-style-type: none"> <li>• Intensive insulin regimen (3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump).</li> <li>• Patient consistently monitors blood glucose 3 or more times per day.</li> <li>• Patient is motivated and knowledgeable about use of continuous glucose monitoring, is adherent to diabetic treatment plan, and participates in ongoing education and support.</li> <li>• Patient must have 1 OR more of the following:             <ul style="list-style-type: none"> <li>○ Dawn phenomenon, known or suspected, Hypoglycemic unawareness (i.e., patient does not have symptoms with hypoglycemia).</li> <li>○ Nocturnal hypoglycemia, known or suspected.</li> <li>○ Postprandial hyperglycemia, known or suspected.</li> <li>○ Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple-dose insulin to insulin pump therapy).</li> </ul> </li> </ul> <p>Unexplained hyperglycemia.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	01/01/2024
<b>P&amp;T Approval Date</b>	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

<p><b>Required Medical Information</b></p>	<p><b>Bone Marrow/Stem Cell Transplant:</b></p> <ul style="list-style-type: none"> <li>• One of the following:           <ul style="list-style-type: none"> <li>○ Patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT) <b>OR</b></li> <li>○ Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis <b>OR</b></li> <li>○ Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy.</li> </ul> </li> </ul> <p><b>Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of acute myeloid leukemia (AML).</li> <li>• Patient has completed induction or consolidation chemotherapy.</li> </ul> <p><b>Febrile Neutropenia Prophylaxis:</b></p> <ul style="list-style-type: none"> <li>• Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:           <ul style="list-style-type: none"> <li>○ Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer.</li> <li>○ Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown.</li> <li>○ Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN.</li> <li>○ Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN <b>AND</b> has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia.</li> <li>○ Patient is receiving myelosuppressive anticancer drugs associated with neutropenia <b>AND</b> has a history of FN or dose-</li> </ul> </li> </ul>
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## Criteria Details

	<p>limiting event during a previous course of chemotherapy (secondary prophylaxis).</p> <p><b>Treatment of High-Risk Febrile Neutropenia:</b></p> <ul style="list-style-type: none"> <li>• Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia.</li> <li>• Diagnosis of febrile neutropenia (FN).</li> <li>• Patient is at high risk for infection-associated complications.</li> </ul> <p><b>Severe Chronic Neutropenia (SCN):</b></p> <ul style="list-style-type: none"> <li>• 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<sup>3</sup>)</li> </ul> <p><b>Acute Radiation Syndrome (ARS):</b></p> <ul style="list-style-type: none"> <li>• Patient was/will be acutely exposed to myelosuppressive doses of radiation cells/mm<sup>3</sup>).</li> </ul> <p><b>Human Immunodeficiency Virus (HIV) Related Neutropenia:</b></p> <ul style="list-style-type: none"> <li>• Patient is infected with HIV virus.</li> <li>• ANC less than or equal to 1,000 (cells/mm<sup>3</sup>).</li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p><b>HIV Related Neutropenia</b> – Hematologist, Oncologist, or Infectious Disease Specialist</p> <p><b>All Other Diagnosis</b> - Hematologist or Oncologist</p>
<b>Coverage Duration</b>	<p><b>Bone Marrow/Stem Cell Transplant:</b> 3 months or duration of therapy.  <b>AML Induction/Consolidation Therapy:</b> 3 months or duration of therapy.  <b>Febrile Neutropenia (FN) Prophylaxis:</b> 3 months or duration of therapy.  <b>Treatment of High-Risk FN:</b> 3 months or duration of therapy.  <b>Severe Chronic Neutropenia (SCN):</b> 12 months.  <b>Acute Radiation Syndrome (ARS):</b> 1 month</p>
<b>Renewal Criteria</b>	
<b>Effective Date</b>	09/01/2024
<b>P&amp;T Approval Date</b>	07/09/2024

# Cyclosporine ophthalmic emulsion (RESTASIS)

## Products Affected

- RESTASIS
- RESTASIS MULTIDOSE

### Prior Authorization Criteria

#### Criteria Details

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

# Deutetrabenazine (AUSTEDO)

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Chorea associated with Huntington’s Disease:</b> Documentation of the degree of chorea present and the impact on functional ability and/or quality of life as a baseline <b>AND</b> documentation of mental status, specifically depression and suicidality.</p> <p><b>Tardive Dyskinesia:</b> 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 <b>AND</b> clear documentation that tardive dyskinesia causes functional impairment <b>AND</b> documentation of the degree of tardive dyskinesia with the AIMS scale as a baseline <b>AND</b> 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 <b>OR</b> evidence the medications precipitating tardive dyskinesia are medically necessary <b>AND</b> trial and failure or contraindication to clonazepam and amantadine.</p>
<b>Age Restrictions</b>	Age 18 and older
<b>Prescriber Restrictions</b>	<b>Huntington’s Disease:</b> neurologist <b>Tardive Dyskinesia:</b> neurologist or psychiatrist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<b>Huntington’s Chorea:</b> clinical response such as improvement in chorea, ability to perform ADLs, reduction in falls, or increase in quality of life. <b>AND</b> documentation of continued monitoring of mental status specifically for depression and suicidality.

### Criteria Details

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

# Dimethyl Fumarate (TECFIDERA)

## Products Affected

- DIMETHYL FUMARATE
- DIMETHYL FUMARATE STARTER PACK

## Prior Authorization Criteria

### Criteria Details

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

# Direct-Acting Antivirals (use in Hepatitis C)

## Products Affected

- LEDIPASVIR-SOFOSBUVIR
- SOFOSBUVIR-VELPATASVIR
- MAVYRET

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Treatment of Hepatitis C:</b></p> <ul style="list-style-type: none"><li>• Expected survival from non-HCV-associated morbidities more than 1 year.</li><li>• Must have all pretreatment testing completed: including genotype, HBV, HIV, and cirrhosis status.</li><li>• Care must be provided by or in consultation with a specialist (hepatologist, gastroenterologist, or infectious disease specialist).</li><li>• 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.</li><li>• 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.</li><li>• Documentation of the prescribed regimen includes a NS3/4a protease inhibitor (glecaprevir, simeprevir, paritaprevir, voxilaprevir).</li><li>• Documentation if the patient has moderate-severe hepatic impairment (Child-Pugh B or Child-Pugh C).</li></ul> <p>Documentation if the prescribed regimen for the retreatment after failure of a DAA due to noncompliance or loss of follow-up and the prescribed</p>
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### Criteria Details

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

# Disposable Insulin Pump (OMNIPOD)

## Products Affected

- OMNIPOD 5
- OMNIPOD DASH

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Insulin dependent diabetes mellitus – pediatric (under age 18)</b></p> <ul style="list-style-type: none"> <li>• Documentation of Type 1 Diabetes Mellitus or Diabetes with C-reactive protein levels indicating insulin dependence.</li> <li>• On intensive insulin therapy (&gt;3 daily insulin injections) requiring frequent self-adjustments for at least 6 months prior to initiation of the insulin pump.</li> <li>• Documentation self-testing of blood glucose at least 4 times per day during the previous 2 months</li> <li>• Evidence of completion of a comprehensive diabetes education program in the last 12 months (member or caregiver/parent).</li> </ul> <p><b>Insulin dependent diabetes mellitus – adult</b></p> <ul style="list-style-type: none"> <li>• All of the above pediatric requirements AND</li> <li>• Documentation of 1 of the following:               <ul style="list-style-type: none"> <li>○ HbA1c &gt;7%</li> <li>○ History of recurring hypoglycemia</li> <li>○ Wide fluctuations in blood glucose before mealtime</li> <li>○ Dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dL</li> <li>○ History of severe glycemic excursions</li> </ul> </li> <li>• Inability to use a traditional (non-disposable) insulin pump.</li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 6 months <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy and in-person visit with provider within the last 6 months.

## Criteria Details

<b>Effective Date</b>	03/01/2024
<b>P&amp;T Approval Date</b>	01/09/024
<b>P&amp;T Revision Date</b>	

# Dornase alfa (PULMOZYME)

## Products Affected

- PULMOZYME

## Prior Authorization Criteria

### Criteria Details

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

# Dronabinol (MARINOL)

## Products Affected

- DRONABINOL

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Nausea and Vomiting Associated with Cancer Chemotherapy (CINV):</b> 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). <b>AIDS anorexia:</b> Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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)  $\geq$  11 or Children's Dermatology Life Quality Index (CDLQI)  $\geq$  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  $\geq$  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
- Inadequate 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  $\geq 7$ ) 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)  $\geq 300$  cells/ $\mu$ L within the past 3 months.
- Chronic bronchitis, defined as a chronic productive cough for  $\geq 3$  months in the past year, in the absence of other known causes of chronic cough.
- $\geq 2$  moderate COPD exacerbation (defined as requiring treatment with either systemic corticosteroids and/or antibiotics) or  $\geq 1$  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].
<b>Age Restrictions</b>	<b>Moderate to Severe Asthma:</b> 6 years and older <b>Atopic Dermatitis:</b> 6 months and older <b>Eosinophilic Esophagitis:</b> 1 year and older <b>CRSwNP:</b> 12 years and older <b>Prurigo Nodularis:</b> 18 years and older <b>COPD:</b> 18 years and older
<b>Prescriber Restrictions</b>	<b>Atopic dermatitis:</b> Prescribed by a Dermatologist <b>Eosinophilic Esophagitis:</b> Prescribed by Gastroenterologist or Immunologist <b>CRSwNP:</b> Prescribed by ENT or Immunologist <b>Prurigo Nodularis:</b> Prescribed by Dermatologist <b>Asthma/COPD:</b> Pulmonologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	03/01/2025
<b>P&amp;T Approval Date</b>	11/08/2022
<b>P&amp;T Revision Date</b>	01/14/2025

# Elagolix (ORLISSA)

## Products Affected

- ORLISSA TAB 150MG

- ORLISSA TAB 200MG

## Prior Authorization Criteria

### Criteria Details

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

# Elefibranor (IQIRVO)

## Products Affected

- IQIRVO TABLETS

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Primary biliary cholangitis:</b> <ul style="list-style-type: none"><li>• Diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following:<ul style="list-style-type: none"><li>○ Biochemical evidence of cholestasis based on ALP elevation</li><li>○ Presence of AMA or other PBC-specific autoantibodies</li><li>○ Histology confirmation after biopsy</li></ul></li><li>• Trial and failure of 12 months of ursodiol.</li><li>• No current decompensated cirrhosis.</li></ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist or hepatologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months; <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documented positive clinical response to therapy.
<b>Effective Date</b>	11/1/2024
<b>P&amp;T Approval Date</b>	9/10/2024
<b>P&amp;T Revision Date</b>	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

	<ul style="list-style-type: none"> <li>• Trial and failure, contraindication, or intolerance to immunosuppressive therapy with antithymocyte globulin (ATG) and cyclosporine</li> <li>• Patient has thrombocytopenia defined as platelet count less than 30,000/mcL</li> </ul> <p><b>Chronic Hepatitis C-Associated Thrombocytopenia:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of chronic hepatitis C-associated thrombocytopenia</li> <li>• One of the following:             <ul style="list-style-type: none"> <li>○ Planning to initiate and maintain interferon-based treatment</li> <li>○ Currently receiving interferon-based treatment</li> </ul> </li> </ul>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist.
<b>Coverage Duration</b>	<p><b>Immune Thrombocytopenia (ITP): Initial:</b> 12 months; <b>Renewal:</b> 12 months</p> <p><b>Aplastic Anemia (severe first-line): Initial:</b> 6 months; <b>Renewal:</b> 12 months</p> <p><b>Aplastic Anemia (severe refractory): Initial:</b> 16 weeks; <b>Renewal:</b> 12 months</p> <p><b>Chronic Hepatitis C-Associated Thrombocytopenia: Initial:</b> 3 months; <b>Renewal:</b> 12 months</p>
<b>Renewal Criteria</b>	Documented positive clinical response to therapy as evidenced by an increase in platelet count.
<b>Effective Date</b>	1/1/2026
<b>P&amp;T Approval Date</b>	11/11/2025
<b>P&amp;T Revision Date</b>	11/11/2025

# Elexacaftor-tezacaftor-ivacaftor (TRIKAFTA)

## Products Affected

- TRIKAFTA

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Cystic Fibrosis</b> <ul style="list-style-type: none"><li>• 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):<ul style="list-style-type: none"><li>○ F508del mutation</li><li>○ A mutation in the CFTR gene that is responsive based on clinical, in vitro, or extrapolated data.</li></ul></li><li>• Not to be used in combination with other CFTR modulator treatments</li></ul>
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Pulmonologist or Specialist affiliated with a CF care center.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	05/01/2025
<b>P&amp;T Approval Date</b>	03/11/2025
<b>P&amp;T Revision Date</b>	05/01/2021, 09/01/2021, 03/11/2025
<b>References</b>	<ul style="list-style-type: none"><li>• Alyftrek [package insert]. Boston, MA: Vertex Pharmaceuticals Inc.; 2025.</li></ul>

# Endothelin Receptor Antagonists

## Products Affected

- Ambrisentan tablets
- Bosentan Tablets

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b><u>Pulmonary Arterial Hypertension</u></b> <ul style="list-style-type: none"><li>• Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)</li></ul>
<b>Age Restrictions</b>	<ul style="list-style-type: none"><li>• Ambrisentan: 18 years of age and over</li><li>• Bosentan: 3 years and up</li></ul>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	9/1/2025
<b>P&amp;T Approval Date</b>	7/13/2021
<b>P&amp;T Revision Date</b>	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

	<ul style="list-style-type: none"> <li>• Patient is at high risk for perioperative transfusions.</li> <li>• Patient is unwilling or unable to donate autologous blood pre-operatively.</li> <li>• Verification of adequate iron stores.</li> </ul> <p><b>Anemia in Myelodysplastic Syndrome (MDS):</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of MDS.</li> <li>• Serum erythropoietin less than or equal to 500mU/mL <b>OR</b> diagnosis of transfusion dependent MDS.</li> </ul> <p>Verification of adequate iron stores.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<p><b>Anemia in HIV or CKD</b>  <b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.</p> <p><b>Anemia due to chemotherapy</b>  <b>Initial:</b> 3 months. <b>Renewal:</b> 3 months.</p> <p><b>Anemia in MDS</b>  <b>Initial:</b> 3 months. <b>Renewal:</b> 12 months.</p> <p><b>Preop Initial:</b> 1 month.</p>
<b>Renewal Criteria</b>	<p><b>Anemia due to CKD:</b></p> <ul style="list-style-type: none"> <li>• One of the following: <ul style="list-style-type: none"> <li>○ Patient is on dialysis and most recent or average Hct over 3 months is 33% or less (Hgb 11g/dL or less)</li> <li>○ Patient is not on dialysis and most recent or average Hct over 3 months is 30% or less (Hgb 10g/dL or less)</li> <li>○ Request is for a pediatric member and most recent or average Hct over 3 months is 36% or less (Hgb 12g/dL or less)</li> </ul> </li> <li>• Decrease in the need for blood transfusion <b>OR</b> Hemoglobin increased greater than or equal to 1d/dL from pre-treatment level</li> <li>• Verification of adequate iron stores</li> </ul> <p><b>Anemia in HIV Patients:</b></p> <ul style="list-style-type: none"> <li>• Most recent or average Hct over 3 months is 36% or less (Hgb 12g/dL or less).</li> <li>• Decrease in the need for blood transfusion <b>OR</b> Hemoglobin increased greater than or equal to 1d/dL from pre-treatment level.</li> </ul>

## 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.

<b>Effective Date</b>	9/1/2024
<b>P&amp;T Approval Date</b>	7/9/2024
<b>P&amp;T Revision Date</b>	7/9/2024

# Erenumbab (AIMOVIG)

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

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

### Criteria Details

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

# Etrasimod arginine (VELSIPITY)

## Products Affected

- VELSIPITY TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Ulcerative Colitis (UC):</b> <ul style="list-style-type: none"><li>• Documentation of moderate-to-severe ulcerative colitis</li><li>• 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:<ul style="list-style-type: none"><li>○ Mesalamine, sulfasalazine OR</li><li>○ Mercaptopurine, azathioprine, OR</li><li>○ Corticosteroids (prednisone, methylprednisolone)</li></ul></li><li>• Trial and failure of both infliximab and adalimumab</li></ul>
<b>Age Restrictions</b>	Must be at least 18 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in collaboration with a Gastroenterologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Evidence of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission.
<b>Effective Date</b>	03/01/2024
<b>P&amp;T Approval Date</b>	01/09/2024
<b>P&amp;T Revision Date</b>	

# Etanercept (ENBREL)

## Products Affected

- ENBREL
- ENBREL SURECLICK

### Prior Authorization Criteria

## Criteria Details

<b>Required Medical Information</b>	<p><b>ALL:</b> must have a negative tuberculin test (TB)</p> <p><b>AS:</b> 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).</p> <p><b>CD:</b> 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 <b>AND</b> one or more non-biologic DMARD (i.e., methotrexate, sulfasalazine).</p> <p><b>PP:</b> 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) <b>OR</b> Involvement of at least 10 percent of body surface area (BSA) <b>OR</b> Psoriasis Area and Severity Index (PASI) score of 12 or greater, <b>AND</b> patient is free of any clinically important active infections <b>AND</b> 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, <b>AND</b> did not respond or non-candidate to a 3-month minimum trial of phototherapy.</p>
<b>Age Restrictions</b>	

## Criteria Details

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

# Etoposide (EVPEPID) (TOPOSAR)

## Products Affected

- ETOPOSIDE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Small cell lung cancer (SCLC):</b> Diagnosis of SCLC.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Fezolinetant (VEOZAH)

## Products Affected

- VEOZAH TAB 45MG

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Vasomotor Symptoms (VMS):</b> <ul style="list-style-type: none"><li>• Diagnosis of moderate-to-severe VMS due to menopause</li><li>• Documented contraindication, intolerance, or inadequate response to at least 2 hormonal therapies AND</li></ul> Documented contraindication, intolerance, or inadequate response to two nonhormonal therapies (e.g., one SNRI and one SSRI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gynecologist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of at least 50% reduction in VMS from baseline.
<b>Effective Date</b>	09/01/2023
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	

# 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<sup>3</sup>).

**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<sup>3</sup>.

## Criteria Details

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

# Fingolimod (GILENYA)

## Products Affected

- GILENYA

## Prior Authorization Criteria

### Criteria Details

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

# Flutamide (EULEXIN)

## Products Affected

- FLUTAMIDE

## Prior Authorization Criteria

### Criteria Details

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

# Fremanezumab-vfrm (AJOVY)

## Products Affected

- AJOVY

### Prior Authorization Criteria

#### Criteria Details

<b>Required Medical Information</b>	<p><b>Diagnosis of episodic migraines:</b> Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Diagnosis of chronic migraines:</b> 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 <b>AND</b> medication overuse headache has been considered and potentially offending medication(s) have been discontinued</p> <p style="text-align: center;"><b>AND</b></p> <p><b>Two of the following:</b> History of failure or contraindication (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine) <b>OR</b> history of failure or contraindications (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) <b>OR</b> 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 <b>OR</b> history of failure or contraindication (after at least a two month trial) or intolerance to Atacand (candesartan) <b>AND</b> medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines</p>
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity <b>AND</b> 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 <b>AND</b>

### 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

<b>Required Medical Information</b>	Diagnosis of episodic cluster headache <b>AND</b> 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 <b>AND</b> medication will not be used in combination with another CGRP inhibitor.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist.
<b>Coverage Duration</b>	<b>Initial:</b> 3 months <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity <b>AND</b> Medication will not be used in combination with another CGRP inhibitor.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# General Oncology

## Products Affected

- Abemaciclib (Verzenio)
- Abiraterone
- Acalabrutinib (Calquence)
- Adagrasib (Krazati)
- Alectinib (Alecensa)
- Alpelisib (Piqray)
- Asciminib (Scemblix)
- Asparaginase Erwinia (Rylaze)
- Avutometinib/Defactinib (Avmapki/Fazynja Pak)
- Belzutifan (Welireg)
- 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)
- Everolimus
- Flutamide (Eulexin)
- Fruquintinib (Fruzaqla)
- Futibatinib (Lytgobi)
- Gefitinib
- Ibrutinib (Imbruvica)
- Inavolisib (Itovebi)
- Infigratinib (Truseltiq)
- Ivosidenib (Tibsovo)
- Lazertinib (Lazcluze)
- Lenvatinib (Lenvima)
- Lomustine (Gleostine)
- Lorlatinib (Lobrena)
- Midostaurin (Rydapt)
- Mobocertinib (Exkivity)
- Nilotinib (Tasigna)
- Niraparib/Abiraterone (Akeega)
- Nirogacestat (Ogsiveo)
- Olaparib (Lynparza)
- Olutasidenib (Rezlidhia)
- Osimertinib (Tagrisso)
- Pacritinib (Vonjo)
- Palbociclib (Ibrance)
- Pazopanib
- Pemigatinib (Pemazyre)
- Pexidartinib (Turalio)
- Pirtobrutinib (Jaypirca)
- Ponatinib (Iclusig)
- Quizartinib (Vanflyta)
- Repotrectinib (Augtyro)
- Ribociclib (Kisqali)
- Selpercatinib (Retevmo)
- Sorafenib
- Sotorasib (Lumakras)
- Sunitinib
- Talazoparib (Talzenna)
- Taletrectinib (Ibtrozi)
- Temozolomide
- Tepotinib (Tepmetko)
- Thioguanine (Tabloid)
- Tivozanib (Fotivda)
- Topotecan (Hycamtin)
- Tovorafenib (Ojemda)
- Trametinib (Mekinist)

- Trifluridine/Tipiracil (Lonsurf)
- Tucatinib (Tukysa)
- Vimseltinib (Romvimza)
- Vorasidinib (Vorango)
- Vorinostat (Zolinza)
- Zanubrutinib (Brukinsa)
- Zongertinib (Hernexeos)

## Prior Authorization Criteria

Criteria Details	
<b>Required Medical Information</b>	Medication is being used for an FDA approved age <b>AND</b> medication is being used for FDA approved indication <b>OR</b> Medication is being used according to National Comprehensive Cancer Network (NCCN) guidelines
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by oncologist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> up to 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	1/1/2026
<b>P&amp;T Approval Date</b>	10/01/2022
<b>P&amp;T Revision Date</b>	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

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

# Glucagon-Like Peptide-1 (GLP1s) Receptor Agonist

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<ul style="list-style-type: none"><li>• Patient must have clinically diagnosed Type 2 Diabetes</li><li>• Patient has had trial of, or contraindication to maximally tolerated dose of metformin.</li></ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months, <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	03/01/2024
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Golimumab (SIMPONI)

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Rheumatoid Arthritis (RA):</b> 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 <b>AND</b> patient is receiving concurrent therapy with methotrexate <b>OR</b> has a contraindication or intolerance to methotrexate.</p> <p><b>Psoriatic Arthritis (PsA):</b> Diagnosis of active PsA with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement.</p> <p><b>Ankylosing Spondylitis (AS):</b> Diagnosis of active ankylosing spondylitis <b>AND</b> minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen).</p> <p><b>Polyarticular Juvenile Idiopathic Arthritis (PJIA):</b> 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.</p> <p><b>Ulcerative Colitis (UC):</b> 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).</p>
<b>Age Restrictions</b>	

## Criteria Details

<b>Prescriber Restrictions</b>	<p><b>RA, AS, PJIA:</b> Prescribed by or in consultation with a rheumatologist</p> <p><b>PsA:</b> Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist</p> <p><b>UC:</b> Prescribed by or in consultation with a gastroenterologist</p>
<b>Coverage Duration</b>	<p><b>RA, PsA, AS, PJIA: Initial:</b> 6 months; <b>Renewal:</b> 12 months</p> <p><b>UC: Initial:</b> 10 weeks; <b>Renewal:</b> 12 months</p>
<b>Renewal Criteria</b>	<p><b>RA, PJIA:</b> 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.</p> <p><b>PsA:</b> 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.</p> <p><b>AS:</b> 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.</p> <p><b>UC:</b> 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.</p>
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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	<b>Initial:</b> 3 months. <b>Renewal:</b> 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

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

## 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

<b>Effective Date</b>	8/1/2024
<b>P&amp;T Approval Date</b>	5/13/2024
<b>P&amp;T Revision Date</b>	

# Guselkumab (TREMFYA)

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

#### Required Medical Information

#### Plaque Psoriasis

- 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

#### Psoriatic Arthritis

- Diagnosis of active psoriatic arthritis
- One of the following:
  - Actively inflamed joints
  - Dactylitis
  - Enthesitis
  - Axial disease
  - Active skin and/or nail involvement

#### Crohn's Disease

- 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

	<ul style="list-style-type: none"> <li>▪ Complications such as obstruction, fever, abdominal mass</li> <li>▪ Abnormal lab values (e.g. C-reactive protein)</li> <li>▪ CD Activity Index (CDAI) greater than 220</li> </ul> <p><b>Ulcerative Colitis</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of moderately to severely active ulcerative colitis</li> <li>• One of the following:             <ul style="list-style-type: none"> <li>○ Documentation of one of the following:                 <ul style="list-style-type: none"> <li>▪ Greater than 6 stools per day</li> <li>▪ Frequent blood in the stools</li> <li>▪ Frequent urgency</li> <li>▪ Presence of ulcers</li> <li>▪ Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)</li> <li>▪ Dependent on, or refractory to, corticosteroids</li> </ul> </li> </ul> </li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<ul style="list-style-type: none"> <li>• <b>Plaque Psoriasis:</b> Dermatologist</li> <li>• <b>Psoriatic Arthritis:</b> Dermatologist Rheumatologist</li> <li>• <b>Crohn's Disease and Ulcerative Colitis:</b> Gastroenterologist</li> </ul>
<b>Coverage Duration</b>	<ul style="list-style-type: none"> <li>• <b>Plaque Psoriasis and Psoriatic Arthritis:</b> <ul style="list-style-type: none"> <li>○ Initial: 6 months</li> <li>○ Renewal: 12 months</li> </ul> </li> <li>• <b>Crohn's Disease and Ulcerative Colitis:</b> <ul style="list-style-type: none"> <li>○ Initial IV: 3 months</li> <li>○ Initial SC: 6 months</li> <li>○ Renewal SC: 12 months</li> </ul> </li> </ul>
<b>Renewal Criteria</b>	<ul style="list-style-type: none"> <li>• <b>Plaque Psoriasis</b> – Documentation of positive clinical response to therapy as evidenced by one of the following:             <ul style="list-style-type: none"> <li>○ Reduction the body surface area (BSA) involvement from baseline</li> <li>○ Improvement in symptoms (e.g., pruritus, inflammation) from baseline</li> </ul> </li> <li>• <b>Psoriatic Arthritis</b> – Documentation of positive clinical response to therapy as evidenced by one of the following:             <ul style="list-style-type: none"> <li>○ Reduction in the total active (swollen and tender) joint count from baseline</li> </ul> </li> </ul>

## Criteria Details

	<ul style="list-style-type: none"><li>○ Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline</li><li>○ Reduction in the body surface area (BSA) involvement from baseline</li> <li>● <b>Crohn's Disease, Ulcerative Colitis</b> – Documentation of positive clinical response to therapy as evidenced by at least one of the following:<ul style="list-style-type: none"><li>○ Improvement in intestinal inflammation (e.g. mucosal healing, improvement in lab values) from baseline</li><li>○ Reversal of high fecal output state</li></ul></li></ul>
<b>Effective Date</b>	9/1/2025
<b>P&amp;T Approval Date</b>	10/28/2022
<b>P&amp;T Revision Date</b>	7/8/2025, 5/8/2023, 10/28/2022

# Imiquimod (ZYCLARA)

## Products Affected

- IMIQUIMOD CREAM 3.75% EXTERNAL

## Prior Authorization Criteria

### Criteria Details

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

# Inclisiran (LEQVIO)

## Products Affected

- LEQVIO SOLUTION

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Established clinical ASCVD:</b></p> <ul style="list-style-type: none"> <li>• Documentation of very high risk ASCVD as evidenced by either:               <ul style="list-style-type: none"> <li>○ History of multiple major ASCVD events <b>OR</b></li> <li>○ One major ASCVD event AND multiple high-risk conditions.</li> </ul> </li> <li>• Documentation of a current LDL greater than or equal to 55 mg/dl.</li> <li>• Documentation that:               <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> <li>• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).</li> </ul> <p><b>Primary or familial hyperlipidemia:</b></p> <ul style="list-style-type: none"> <li>• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.</li> <li>• Documentation of current LDL greater than 100 mg/dL.</li> <li>• Documentation that:               <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> <li>• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).</li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

## Criteria Details

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

# Insulin Degludec (TRESIBA)

## Products Affected

- TRESIBA FLEXTOUCH U-100 & U-200

## Prior Authorization Criteria

### Criteria Details

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

# Interferon Alfa-2b (INTRON A)

## Products Affected

- INTRON A

## Prior Authorization Criteria

### Criteria Details

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

## Criteria Details

<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Interferon beta-1a (AVONEX)

## Products Affected

- AVONEX PEN
- AVONEX PREFILLED

## Prior Authorization Criteria

### Criteria Details

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

# 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

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

# Interferon beta-1b (EXTAVIA)

## Products Affected

- EXTAVIA INJ 0.3MG

## Prior Authorization Criteria

### Criteria Details

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

# Interferon Gamma-1b (ACTIMMUNE)

## Products Affected

- ACTIMMUNE

## Prior Authorization Criteria

### Criteria Details

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

# Ivacaftor (KALYDECO)

## Products Affected

- KALYDECO

## Prior Authorization Criteria

### Criteria Details

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

# Ivermectin (STROMEKTOL)

## Products Affected

- IVERMECTIN

## Prior Authorization Criteria

### Criteria Details

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

# 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) <b>AND</b> trial and failure, contraindication, or intolerance to Cimzia.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p><b>Plaque Psoriasis (PP):</b> Prescribed by or in consultation with a dermatologist</p> <p><b>Psoriatic Arthritis (PsA):</b> Prescribed by or in consultation with a dermatologist or rheumatologist</p> <p><b>Ankylosing Spondylitis (AS):</b> Prescribed by or in consultation with a rheumatologist</p> <p><b>Non-radiographic Axial Spondyloarthritis:</b> Prescribed by or in consultation with a rheumatologist</p>
<b>Coverage Duration</b>	<b>Initial:</b> 12 months; <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	<p><b>PsO:</b> 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.</p> <p><b>PsA:</b> 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.</p> <p><b>AS, nr-axSpA:</b> 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.</p>
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Lacosamide (VIMPAT)

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b><u>Focal Seizures</u></b> <ul style="list-style-type: none"><li>• Documentation confirming epilepsy or seizure disorder</li><li>• <b>Solution only:</b> Member under age 10 or unable to use tablets</li></ul> <b><u>Primary Generalized Tonic-Clonic Seizures</u></b> <ul style="list-style-type: none"><li>• Documentation confirming epilepsy or seizure disorder</li><li>• <b>Solution only:</b> Member under age 10 or unable to use tablets</li></ul>
<b>Age Restrictions</b>	<b>Solution only</b> One of the following: <ul style="list-style-type: none"><li>• Pediatric member age 10 or under</li><li>• Documentation inability of the member to use the preferred tablet formulation</li></ul>
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> Lifetime.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	5/1/2025
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	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

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

# Lasmiditan (REYVOW)

## Products Affected

- REYVOW 100MG TAB
- REYVOW 50MG TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	Medication intended for use for acute use for the treatment of migraine headaches <b>AND</b> documentation patient is on preventative therapy <b>AND</b> 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) <b>OR</b> trial and failure to intolerance to NSAID treatment alone if triptans contraindicated <b>OR</b> contraindication to all triptans and NSAIDs
<b>Age Restrictions</b>	Patient is 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by neurologist or headache specialist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months <b>Renewal:</b> 6 months
<b>Renewal Criteria</b>	Documented positive clinical response to therapy
<b>Effective Date</b>	07/01/2023
<b>P&amp;T Approval Date</b>	05/09/2023
<b>P&amp;T Revision Date</b>	

# Lebrikizumab (EBGLYSS)

## Products Affected

- Ebglyss autoinjector
- Ebglyss prefilled syringe

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Atopic dermatitis:</b></p> <ul style="list-style-type: none"> <li>• Diagnosed with severe atopic dermatitis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) <math>\geq</math> 11 or Children's Dermatology Life Quality Index (CDLQI) <math>\geq</math> 13 (or severe score on another validated tool)</li> <li>• One or more of the following:               <ul style="list-style-type: none"> <li>○ At least 10% of body surface area involvement</li> <li>○ Hand, foot, or mucous membrane involvement</li> </ul> </li> <li>• Documented contraindication or failed trial to ALL of the following:               <ul style="list-style-type: none"> <li>○ Moderate-high potency corticosteroid (e.g., clobetasol, fluocinonide, fluticasone)</li> <li>○ Topical calcineurin inhibitor (e.g. tacrolimus)</li> <li>○ Oral immunomodulator therapy (e.g. cyclosporine, methotrexate, azathioprine, mycophenolate mofetil) <b>OR</b> the member is oral corticosteroid dependent.</li> </ul> </li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy
<b>Effective Date</b>	1/1/2025
<b>P&amp;T Approval Date</b>	11/12/2024
<b>P&amp;T Revision Date</b>	11/12/2024

# Lenacapavir (Sunlenca)

## Products Affected

- Sunlenca Therapy Pack
- Sunlenca Subcutaneous

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b><u>Multi-Drug-Resistant HIV</u></b> <ul style="list-style-type: none"><li>• 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</li><li>• Will be used in combination with an optimized baseline regimen (OBR)</li><li>• Current ARV regimen has been stable for at least 2 months</li><li>• HIV-1 RNA is <math>\geq 400</math> copies/mL</li></ul>
<b>Prescriber Restrictions</b>	HIV Specialist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<ul style="list-style-type: none"><li>• Continues to be used in combination with an optimized background regimen (OBR)</li><li>• Provider states that patient continues to receive clinical benefit from the treatment</li></ul>
<b>Effective Date</b>	4/1/2023
<b>P&amp;T Approval Date</b>	3/14/2023
<b>P&amp;T Revision Date</b>	3/14/2023

# Lenacapavir (Yeztugo)

## Products Affected

- Yeztugo inj.
- Yeztugo Tablets

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b><u>Pre-Exposure Prophylaxis (PrEP)</u></b> <ul style="list-style-type: none"><li>• Confirmation the drug is being used for PrEP (a different product is used for treatment)</li><li>• Submission of medical records documenting both of the following U.S. Food and Drug (FDA)-approved tests prior to use of Yeztugo:<ul style="list-style-type: none"><li>○ Negative HIV-1 antigen/antibody test</li><li>○ Negative HIV-1 RNA assay</li></ul></li><li>• Trial and failure, contraindication, or intolerance to generic emtricitabine-tenofovir disoproxil fumarate 200/300mg.</li></ul>
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<ul style="list-style-type: none"><li>• Provider attests that patient is adherent to the testing appointments and scheduled injections of Yeztugo</li><li>• Submission of medical records documenting both of the following U.S. Food and Drug (FDA)-approved tests prior to use of Yeztugo:<ul style="list-style-type: none"><li>○ Negative HIV-1 antigen/antibody test</li><li>○ Negative HIV-1 RNA assay</li></ul></li></ul>
<b>Effective Date</b>	11/1/2025
<b>P&amp;T Approval Date</b>	9/9/2025
<b>P&amp;T Revision Date</b>	9/9/2025

# Lidocaine Topical Anesthetic (LIDODERM)

## Products Affected

- LIDOCAINE EXTERNAL PATCH 5%

## Prior Authorization Criteria

### Criteria Details

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

# Lifitegrast (XIIDRA)

## Products Affected

- XIIDRA

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p>The patient has a diagnosis of lack of tear production due to ocular inflammation associated with keratoconjunctivitis sicca <b>AND ONE</b> of the following:</p> <ul style="list-style-type: none"><li>• The patient is not currently using a topical ophthalmic anti-inflammatory drug or punctal plug <b>OR</b></li><li>• The patients current use of topical ophthalmic anti-inflammatory drug or punctal plug will be discontinued before starting the requested agent <b>AND</b> The patient has previously tried or is currently using aqueous enhancements (e.g. artificial tears, gels, ointments) <b>OR</b></li><li>• The patient has a documented intolerance, contraindication, or hypersensitivity to aqueous enhancements.</li></ul> <p>The patient is not currently using Restasis <b>OR</b> the patients current use of Restasis will be discontinued before starting Xiidra.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Linezolid (ZYVOX)

## Products Affected

- LINEZOLID
- LINEZOLID IN SODIUM CHLORIDE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	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 <b>OR</b> clinically documented infection that is susceptible to linezolid if the patient has failed treatment with antibiotics that the organism is susceptible <b>OR</b> clinically documented Vancomycin-Resistant Enterococcus faecium infection <b>OR</b> clinically documented MRSA <b>AND</b> has failed or is intolerant to Vancomycin if the organism is susceptible to Vancomycin.
<b>Age Restrictions</b>	<b>Solution only</b> One of the following: <ul style="list-style-type: none"><li>• Pediatric member age 10 or under</li><li>• Documentation inability of the member to use the preferred tablet formulation</li></ul>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an Infectious Disease specialist.
<b>Coverage Duration</b>	<b>Initial:</b> length of treatment. <b>Renewal:</b> length of treatment.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	5/1/2024
<b>P&amp;T Approval Date</b>	3/12/2024
<b>P&amp;T Revision Date</b>	3/12/2024

# Lisdexamfetamine (VYVANSE)

## Products Affected

- Lisdexamfetamine

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>ADHD:</b> 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). <b>BED:</b> Clinical documentation confirming binge eating disorder diagnosis per DSM-5 criteria <b>AND</b> trial and failure of at least two therapeutic alternatives including SSRIs, topiramate, and/or methylphenidate.
<b>Age Restrictions</b>	<b>BED:</b> 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	03/01/2025
<b>P&amp;T Approval Date</b>	01/14/2025
<b>P&amp;T Revision Date</b>	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

<b>Required Medical Information</b>	<p><b>Cancer, end of life, or palliative care:</b> No coverage restrictions.</p> <p><b>Non-cancer/end of life care:</b> Documented use of current and/or recent usage of short-acting opioids for at least 15 days prior to long-acting opioids.</p> <ul style="list-style-type: none"> <li>• <b>For opioid naive (14 or fewer days filled in previous 120 days):</b> 7-day maximum quantity limit, equal to or less than 50 MED [morphine equivalents per day].</li> </ul>
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### Criteria Details

	<ul style="list-style-type: none"><li>• <b>For opioid experienced (greater than or equal to 15 days filled in previous 120 days):</b> equal to or less than 90 MED [morphine equivalents per day].</li></ul> Restricted to 2 fills in a 60-day period for both naive <b>AND</b> experienced.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Lotilaner (XDEMVY)

## Products Affected

- Xdemvy 0.25% Ophthalmic solution

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Diagnosis:</b> Demodex Blepharitis <ul style="list-style-type: none"><li>• Documentation of at least mild erythema of the upper eyelid margin</li><li>• Presence of mites upon examination of eyelashes by light microscopy or presence of collarettes on slit lamp examination</li></ul>
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Optometrist or Ophthalmologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 weeks. <b>Renewal:</b> No renewals allowed
<b>Renewal Criteria</b>	
<b>Effective Date</b>	5/1/2024
<b>P&amp;T Approval Date</b>	3/12/2024
<b>P&amp;T Revision Date</b>	3/12/2024

# Lumacaftor/ivacaftor (ORKAMBI)

## Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

## Prior Authorization Criteria

### Criteria Details

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

# Melphalan (ALKERAN)

## Products Affected

- MELPHALAN

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Multiple myeloma:</b> Diagnosed with multiple myeloma prescribed for palliative treatment of multiple myeloma. <b>Ovarian cancer:</b> Diagnosed with ovarian cancer prescribed for palliative treatment of nonresectable epithelial ovarian carcinoma.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Mesna (MESNEX)

## Products Affected

- MESNEX

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Prevention of ifosfamide-induced hemorrhagic cystitis:</b> Patient is receiving ifosfamide therapy <b>AND</b> prescribed to follow IV mesna administration for ifosfamide doses less than or equal to 2g/m <sup>2</sup> /day.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Methylphenidate solution/chewable

## Products Affected

- METHYLPHENIDATE HCL ORAL SOLUTION
- METHYLPHENIDATE HCL ORAL TABLET CHEWABLE

## Prior Authorization Criteria

### Criteria Details

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

# Mirabegron (Myrbetriq)

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## Products Affected

- Mirabegron ER tablets

<b>Covered Uses</b>	<ul style="list-style-type: none"> <li>• All Food and Drug Administration (FDA)-approved indications not otherwise excluded by plan design             <ul style="list-style-type: none"> <li>○ Overactive Bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency</li> <li>○ Neurogenic detrusor overactivity in pediatric members</li> </ul> </li> </ul>
<b>Required Medical Information and Criteria</b>	<p><b><u>Overactive Bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency</u></b></p> <ul style="list-style-type: none"> <li>• Documented trial and failure, intolerance, or contraindication to at least 3 of the following:             <ul style="list-style-type: none"> <li>○ Oxybutynin IR or ER</li> <li>○ Fesoterodine</li> <li>○ Solifenacin</li> <li>○ Tolterodine IR or ER</li> <li>○ Trospium IR or ER (requires step therapy through oxybutynin)</li> </ul> </li> </ul> <p><b><u>Neurogenic Detrusor Overactivity in pediatric members</u></b></p> <ul style="list-style-type: none"> <li>• Is there documented trial and failure, intolerance, or contraindication to both of the following:             <ul style="list-style-type: none"> <li>○ Oxybutynin IR or ER</li> <li>○ Solifenacin</li> </ul> </li> </ul>
<b>Renewal Criteria</b>	<ul style="list-style-type: none"> <li>• Documentation of positive clinical response to therapy</li> </ul>
<b>Age Restriction</b>	<ul style="list-style-type: none"> <li>• 3 years of age and older</li> </ul>
<b>Prescriber Restriction</b>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<b>Coverage Duration</b>	<ul style="list-style-type: none"> <li>• <b>All Diagnoses:</b></li> </ul>

	<ul style="list-style-type: none"><li>○ Initial: 12 months</li><li>○ Renewal: 12 months</li></ul>
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Effective Date:	7/1/2025
P&T Approval Date:	5/13/2025
P&T Revision Date:	5/13/2025

<b>References</b>
<ul style="list-style-type: none"><li>• 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.</li><li>• Myrbetriq [package insert]. Northbrook, IL: Astellas.; 2021.</li></ul>

# Mirikizumab-mrkz (OMVOH)

## Products Affected

- Omvoh

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>All diagnoses:</b></p> <ul style="list-style-type: none"><li>• Initial testing for latent TB and treatment, if necessary, before starting treatment.</li><li>• No current active infection at initiation of therapy.</li><li>• Risks and benefits documented in cases of chronic or recurrent infection.</li><li>• Will NOT be used in combination with another biologic or Otezla</li></ul> <p><b>Ulcerative Colitis (UC):</b></p> <ul style="list-style-type: none"><li>• Documentation of moderate-to-severe ulcerative colitis</li><li>• 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:<ul style="list-style-type: none"><li>• Mesalamine, sulfasalazine OR</li><li>• Mercaptopurine, azathioprine, OR</li><li>• Corticosteroids (prednisone, methylprednisolone)</li><li>• Trial and failure of both infliximab and adalimumab</li></ul></li></ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultations with a Gastroenterologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Evidence of a significant response such as a decrease in bloody stools per day or elimination of signs of toxicity.
<b>Effective Date</b>	7/1/2024
<b>P&amp;T Approval Date</b>	5/14/2024

## Criteria Details

P&T Revision Date	
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# Mitapivat (PYRUKYND)

## Products Affected

- PYRUKYND

## Prior Authorization Criteria

### Criteria Details

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

# Mitotane (LYSODREN)

## Products Affected

- LYSODREN

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Adrenocortical carcinoma:</b> Diagnosed with inoperable (functional or nonfunctional) adrenocortical carcinoma.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Mobocertinib (EXKIVITY)

## Products Affected

- Exkivity

## Prior Authorization Criteria

### Criteria Details

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

# Naltrexone (VIVITROL)

## Products Affected

- VIVITROL INJ.

## Prior Authorization Criteria

### Criteria Details

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

# Nilutamide (NILANDRON)

## Products Affected

- NILUTAMIDE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Metastatic prostate cancer:</b> Diagnosed with metastatic prostate cancer. Prescribed in combination with surgical castration <b>AND</b> documentation of current liver function.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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

	<ul style="list-style-type: none"> <li>• Documented trial and failure of at least 6 weeks of maximally tolerated doses of all the following:             <ul style="list-style-type: none"> <li>○ 1<sup>st</sup> generation antihistamine – (e.g., doxepin, hydroxyzine)</li> <li>○ 2<sup>nd</sup> generation antihistamine – (e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine)</li> <li>○ Histamine Type-2 Receptor Antagonists (e.g., famotidine, cimetidine)</li> <li>○ Leukotriene inhibitor (e.g., montelukast, zafirlukast)</li> </ul> </li> </ul> <p><b>IgE-Mediated Food Allergy:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following:             <ul style="list-style-type: none"> <li>○ Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food,</li> <li>○ Positive food specific IgE (greater than or equal to 6 kUA/L),</li> <li>○ 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.</li> </ul> </li> <li>• Clinical history of IgE mediated food allergy.</li> <li>• Used in conjunction with food allergen avoidance.</li> <li>• Both of the following:             <ul style="list-style-type: none"> <li>○ 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,</li> <li>○ Dosing is according to serum total IgE levels and body weight.</li> </ul> </li> <li>• Xolair will not be used concomitantly with Palforzia.</li> <li>• Attestation that the member is co-prescribed epinephrine or has epinephrine at home.</li> </ul>
<p><b>Age Restrictions</b></p>	<p><b>Asthma:</b> 6 years of age and older  <b>CIU:</b> 12 years of age and older  <b>CRSwNP:</b> 18 years of age and older  <b>IgE Mediated Food Allergy:</b> 1 year of age and older</p>
<p><b>Prescriber Restrictions</b></p>	<p><b>Asthma:</b> Prescribed by or in consultation with a pulmonologist or immunologist.  <b>CIU:</b> Prescribed by or in consultation with an immunologist.  <b>CRSwNP:</b> Prescribed by or in consultation with an allergist or ENT.  <b>IgE Mediated Food Allergy:</b> Prescribed by or in consultation with an allergist or immunologist.</p>
<p><b>Coverage Duration</b></p>	<p><b>Asthma - Initial:</b> 6 months. <b>Renewal:</b> 12 months.  <b>CRSwNP - Initial:</b> 6 months. <b>Renewal:</b> 12 months.  <b>CIU - Initial:</b> 4 months. <b>Renewal:</b> 6 months.  <b>IgE Mediated Food Allergy - Initial:</b> 6 months. <b>Renewal:</b> 12 months.</p>

## Criteria Details

<b>Renewal Criteria</b>	<b>IgE Mediated Food Allergy:</b> <ul style="list-style-type: none"><li>• 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).</li><li>• Used in conjunction with food allergen avoidance.</li><li>• Dosing will continue to be based on body weight and pretreatment IgE serum levels.</li></ul> <b>All Other Diagnoses:</b> Documentation of clinically significant improvement in symptoms.
<b>Effective Date</b>	9/1/2024
<b>P&amp;T Approval Date</b>	7/9/2024
<b>P&amp;T Revision Date</b>	7/9/2024

# Paliperidone (INVEGA HAFYERA)

## Products Affected

- INVEGA HAFYERA

## Prior Authorization Criteria

### Criteria Details

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

# Pancrelipase (CREON) (PANCREAZE)

## Products Affected

- PANCREAZE
- CREON

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p>Confirmed diagnosis of cystic fibrosis <b>OR</b> history of pancreatectomy <b>OR</b> diagnosis of exocrine pancreatic cancer <b>OR</b> diagnosis of chronic pancreatitis confirmed by imaging <b>OR</b> confirmed diagnosis of pancreatic insufficiency confirmed with one of the following methods:</p> <ul style="list-style-type: none"> <li>• Steatorrhea with fecal fat determination <b>OR</b></li> <li>• Measurement of fecal elastase <b>OR</b> Secretin or CCK pancreatic function testing <b>OR</b></li> </ul> <p>Two of the following CFTR mutations (G542X, W1282X, R553X, 621+1G&gt;T, 1717-1G&gt;A, 3120+1G&gt;A , R1162X, 3659delC, 1898+1G&gt;A, 2184delA, 711+1G&gt;T, F508del, I507del, G551D, N1303K, R560T).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# PCSK9 inhibitors

## Products Affected

- PRALUENT
- REPATHA

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Established clinical atherosclerotic cardiovascular disease (ASCVD):</b></p> <ul style="list-style-type: none"> <li>• Confirmed diagnosis of atherosclerotic cardiovascular disease (ASCVD).</li> <li>• Documentation of a current LDL greater than or equal to 55 mg/dl.</li> <li>• Documentation that:             <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> </ul> <p><b>Primary or familial hyperlipidemia:</b></p> <ul style="list-style-type: none"> <li>• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.</li> <li>• Documentation of current LDL greater than 100 mg/dL.</li> <li>• Documentation that:             <ul style="list-style-type: none"> <li>○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins <b>AND</b></li> <li>○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.</li> </ul> </li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documented positive clinical response to therapy (significant decrease in lipid levels).

## Criteria Details

<b>Effective Date</b>	11/1/2024
<b>P&amp;T Approval Date</b>	1/11/2022
<b>P&amp;T Revision Date</b>	01/11/2022, 09/10/2024

# 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

<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Patient must be between 4 and 17 at therapy initiation
<b>Prescriber Restrictions</b>	Prescribed by allergist or immunologist enrolled in Palforzia REMS program
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Currently receiving medication byway of previously approved SHP authorization or documents showing <b>Initial</b> 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.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Pegfilgrastim (NEULASTA)

## Products Affected

- NEULASTA
- NEULASTA ONPRO

## Prior Authorization Criteria

### Criteria Details

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

## Criteria Details

	<b>Initial FN, ARS:</b> 1 month.
<b>Renewal Criteria</b>	<b>Renewal Criteria</b> for CFN, Secondary prophylaxis FN, <b>AND</b> NDDC documentation of therapy continuation: 3-month additional approval. <b>Renewal Criteria</b> for FN <b>AND</b> ARS documentation of therapy continuation: 1-month additional approval.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Phosphodiesterase Type 5 (PDE5) inhibitors

## Products Affected

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

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b><u>Pulmonary Arterial Hypertension</u></b> <ul style="list-style-type: none"><li>• Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)</li></ul>
<b>Age Restrictions</b>	<b>Solution only</b> One of the following: <ul style="list-style-type: none"><li>• Pediatric member age 10 or under</li></ul> Documentation inability of the member to use the preferred tablet formulation
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist.
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	9/1/2025
<b>P&amp;T Approval Date</b>	7/13/2021
<b>P&amp;T Revision Date</b>	7/8/2025, 3/12/2024, 7/13/2021

# Pirtobrutinib (JAYPIRCA)

## Products Affected

- JAYPIRCA 50MG
- JAYPIRCA 100MG

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Mantle Cell Lymphoma (MCL):</b> <ul style="list-style-type: none"><li>• Diagnosis of MCL confirmed by histology</li><li>• Tried and failed at least 2 prior therapies of which one was with a BTKi</li><li>• ECOG performance status score of 0 to 2</li></ul> <b>Other Diagnosis</b> <ul style="list-style-type: none"><li>• Diagnosis as supported in National Comprehensive Cancer Network (NCCN) guidelines</li></ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by oncologist
<b>Coverage Duration</b>	<b>Initial:</b> 2 months. <b>Renewal:</b> 4 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	09/01/2023
<b>P&amp;T Approval Date</b>	07/11/2023
<b>P&amp;T Revision Date</b>	

# Pitolisant (WAKIX)

## Products Affected

- WAKIX 4.45MG TAB
- WAKIX 17.8NG TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<ul style="list-style-type: none"> <li>• Confirmation of diagnosis of narcolepsy based on polysomnography AND a multiple sleep latency test.</li> <li>• Documentation that CYP2D6 testing has been done, and the dosing will be adjusted if the patient is a poor metabolizer.</li> <li>• For Excessive Daytime Sleepiness (EDS) the following is required:             <ul style="list-style-type: none"> <li>○ Documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated measure)</li> <li>○ Trial and failure or contraindication to ALL the following:                 <ul style="list-style-type: none"> <li>▪ Modafinil (at least 200mg dose) AND armodafinil</li> <li>▪ Mixed amphetamine salts, methylphenidate or dexamethylphenidate, AND dextroamphetamine</li> <li>▪ Sunosi (solriamfetol)</li> <li>▪ A sodium oxybate product</li> </ul> </li> </ul> </li> <li>• For Cataplexy the following is required:             <ul style="list-style-type: none"> <li>○ Diagnosis of Cataplexy confirmed by a specialist.</li> <li>○ Trial and failure or contraindication to ALL the following:                 <ul style="list-style-type: none"> <li>▪ SSRI antidepressant (e.g. fluoxetine)</li> <li>▪ SNRI antidepressant (e.g. venlafaxine and duloxetine)</li> <li>▪ Tricyclic antidepressant (e.g. clomipramine)</li> <li>▪ Sodium oxybate product titrated to maximally tolerated dose.</li> </ul> </li> </ul> </li> </ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Exclusions</b>	<ul style="list-style-type: none"> <li>• Severe renal or hepatic impairment</li> <li>• Pregnant or actively trying to conceive</li> </ul>
<b>Prescriber Restrictions</b>	Prescribed by Sleep Specialist or Neurologist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> 6 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.

## Criteria Details

<b>Effective Date</b>	03/01/2025
<b>P&amp;T Approval Date</b>	01/14/2025
<b>P&amp;T Revision Date</b>	01/14/2025

# Plozasiran (Redemplo)

## Products Affected

- Redemplo Prefilled Syringe 25mg/0.5mL

### Prior Authorization Criteria

#### Criteria Details

<b>Required Medical Information</b>	<ul style="list-style-type: none"> <li>• Diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia).</li> <li>• One of the following:             <ul style="list-style-type: none"> <li>○ 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</li> <li>○ A North American FCS (NAFCS) Score of greater than or equal to 45 or</li> <li>○ A Moulin score greater than 10.</li> </ul> </li> <li>• Both of the following:             <ul style="list-style-type: none"> <li>○ One of the following:                 <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ 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])</li> </ul> </li> <li>○ Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug</li> </ul> </li> <li>• Requested drug will be used as adjunct to a low-fat diet.</li> <li>• Requested drug will not be used in combination with Tryngolza (olezarsen)</li> </ul>
<b>Prescriber Restrictions</b>	Prescribed by a Cardiologist, Endocrinologist, Gastroenterologist, or Lipid specialist (lipidologist)
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	<ul style="list-style-type: none"> <li>• Patient demonstrates positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline) and</li> </ul>

### Criteria Details

	<ul style="list-style-type: none"><li>Requested drug will not be used in combination with Tryngolza (olezarsen)</li></ul>
<b>Effective Date</b>	05/01/2026
<b>P&amp;T Approval Date</b>	03/10/2026
<b>P&amp;T Revision Date</b>	03/10/2026

# Pramlintide Acetate (SYMLIN)

## Products Affected

- SYMLINPEN 60
- SYMLINPEN 120

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p>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 <b>AND</b> who meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Are currently on mealtime insulin.</li> <li>• Have an HbA1c less than or equal to 9%.</li> <li>• Are monitoring blood glucose levels regularly <b>AND</b> reliably (3 or more times per day).</li> <li>• Are capable of monitoring blood glucose levels pre- <b>AND</b> post-meals <b>AND</b> at bedtime.</li> <li>• Have failed to achieve adequate control of blood glucose levels despite individualized management of their insulin therapy.</li> </ul> <p>Are receiving ongoing care under the guidance of a health care provider skilled in use of insulin <b>AND</b> supported by the services of a diabetes educator.</p>
<b>Age Restrictions</b>	Patient must be 18 years or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Pretomanid

## Products Affected

- PRETOMANID TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b><u>Pulmonary tuberculosis</u></b></p> <ul style="list-style-type: none"><li>• Evidence of extensively drug-resistant active pulmonary tuberculosis (XDR-TB) caused by mycobacterium tuberculosis.<ul style="list-style-type: none"><li>○ 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.</li></ul></li><li>• Pretomanid is prescribed as part of a guideline recommended multi-drug treatment regimen.</li></ul>
<b>Age Restrictions</b>	Patient must be 14 years or older.
<b>Exclusion Criteria</b>	<ul style="list-style-type: none"><li>• Use outside of recognized treatment guidelines.</li><li>• Medication is being received through a county clinic with a state funded TB program.</li></ul>
<b>Prescriber Restrictions</b>	Infectious Disease
<b>Coverage Duration</b>	<b>Pulmonary tuberculosis:</b> 24 weeks
<b>Renewal Criteria</b>	N/A
<b>Effective Date</b>	05/01/2025
<b>P&amp;T Approval Date</b>	03/11/2025
<b>P&amp;T Revision Date</b>	03/11/2025

# Priftin (rifapentine)

## Products Affected

- Priftin

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Latent tuberculosis:</b> <ul style="list-style-type: none"><li>• Used in combination with isoniazid</li></ul> <b>Active tuberculosis:</b> <ul style="list-style-type: none"><li>• Priftin will be used as part of multi-drug regimen</li></ul>
<b>Age Restrictions</b>	<ul style="list-style-type: none"><li>• Age ≥ 2 years old with latent TB</li><li>• Age ≥ 12 years old with active TB</li></ul>
<b>Exclusion Criteria</b>	<ul style="list-style-type: none"><li>• The drug will NOT be received from a county clinic with a state funded TB program.</li></ul>
<b>Prescriber Restrictions</b>	<ul style="list-style-type: none"><li>• <b>Latent TB:</b> Not limited by specialty</li><li>• <b>Active TB:</b> Infectious disease specialist required for multidrug resistant cases only</li></ul>
<b>Coverage Duration</b>	<b>Latent TB:</b> 3 months. <b>Active TB:</b> 6 months.
<b>Renewal Criteria</b>	N/A
<b>Effective Date</b>	5/1/2025
<b>P&amp;T Approval Date</b>	3/12/2024
<b>P&amp;T Revision Date</b>	3/11/2025, 3/12/2024

# Procarbazine (MATULANE)

## Products Affected

- MATULANE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	Diagnosed with Hodgkin lymphoma.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Ranolazine (RANEXA)

## Products Affected

- RANOLAZINE ER

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Resmetirom (REZDIFFRA)

## Products Affected

- Rezdiffra 60MG/80MG/100MG TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<ul style="list-style-type: none"><li>• Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)</li><li>• Patient does not have cirrhosis (e.g. decompensated cirrhosis)</li><li>• Submission of medical records (e.g. chart notes) showing diagnosis has been confirmed by one of the following:<ul style="list-style-type: none"><li>○ FibroScan-aspartate aminotransferase (FAST)</li><li>○ MRI-aspartate aminotransferase (MAST)</li><li>○ Liver biopsy</li></ul></li><li>• Submission of medical records (e.g. chart notes) showing disease is fibrosis stage F2 or F3 as confirmed by one of the following:<ul style="list-style-type: none"><li>○ FibroScan</li><li>○ Fibrosis-4 index (FIB-4)</li><li>○ Magnetic resonance Elastography (MRE)</li></ul></li><li>• Presence of greater than or equal to 3 metabolic risk factors (e.g., Type 2 diabetes, hypertension, obesity)</li><li>• 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)</li></ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by Gastroenterologist; Hepatologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Patient demonstrates positive response to therapy (e.g., MASH resolution, fibrosis stage improvement, etc.) AND Submission of medical

### Criteria Details

	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)
<b>Effective Date</b>	7/1/2024
<b>P&amp;T Approval Date</b>	5/14/2024
<b>P&amp;T Revision Date</b>	

# Ribavirin (VIRAZOLE)

## Products Affected

- RIBAVIRIN INHALATION

## Prior Authorization Criteria

### Criteria Details

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

# Rifaximin (XIFAXAN)

## Products Affected

- XIFAXAN

## Prior Authorization Criteria

### Criteria Details

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

# Rimegepant (NURTEC)

## Products Affected

- NURTEC ODT

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b>Acute treatment:</b> Diagnosis of migraine with or without aura <b>AND</b> will be used for the acute treatment of migraine <b>AND</b> patient has fewer than 15 headache days per month <b>AND</b> trial and failure or intolerance to 3 generic triptans or contraindications to all triptans and NSAID combined treatment <b>OR</b> trial and failure or intolerance to NSAID treatment alone if triptans contraindicated <b>OR</b> contraindication to all triptans and NSAIDs <b>AND</b> medication will not be used in combination with another CGRP inhibitor <b>AND</b> 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.</p> <p><b>Prophylaxis treatment:</b> Diagnosis of episodic migraines <b>AND</b> patient has 4 to 18 migraine days per month but no more than 18 headache days per month <b>AND</b> 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 <b>AND</b> not used in combination with another CGRP inhibitor.</p>
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist
<b>Coverage Duration</b>	<b>Acute Initial:</b> 3 months; <b>Renewal:</b> 12 months <b>Prophylaxis Initial:</b> 6 months; <b>Renewal</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy
<b>Effective Date</b>	

<b>Criteria Details</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p><b>PsA:</b> Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist.</p> <p><b>CD/UC:</b> Prescribed by or in consultation with a gastroenterologist</p> <p><b>PsO:</b> Prescribed by or in consultation with a dermatologist</p>
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	<p><b>PsO:</b> Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction in the body surface area (BSA) involvement from baseline <b>OR</b> improvement in symptoms (e.g., pruritus, inflammation) from baseline.</p> <p><b>PsA:</b> 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.</p> <p><b>CD/UC:</b> 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.</p>
<b>Effective Date</b>	10/1/2024
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	7/9/2024

# Risdiplam (EVRYSDI)

## Products Affected

- EVRYSDI SOL 0.75MG/ML

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Spinal Muscular Atrophy (SMA):</b> <ul style="list-style-type: none"><li>• Confirmed (via genetic testing) diagnosis of 5q-autosomal recessive SMA (type 1, 2 or 3)</li><li>• Patient is not dependent on invasive ventilation or tracheostomy OR use of non-invasive ventilation beyond uses for sleeping</li><li>• Is not receiving concomitant chronic SMN modifying therapy such as Spinraza</li></ul> <p>Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> up to 12 months.
<b>Renewal Criteria</b>	Documentation of clinical improvement from baseline in motor functionality confirmed by standard exams (e.g. BSID-III, CHOP INTEND, HINE-2, RULM test)
<b>Effective Date</b>	09/01/2023
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	

# Roflumilast (DALLIRESP)

## Products Affected

- DALIRESP

## Prior Authorization Criteria

### Criteria Details

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

# Sacubitril/Valsartan (ENTRESTO)

## Products Affected

- ENTRESO

## Prior Authorization Criteria

### Criteria Details

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

# Seladelpar (LIVDELZI)

## Products Affected

- Livdelzi Capsules

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Primary biliary cholangitis:</b> <ul style="list-style-type: none"><li>• Diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following:<ul style="list-style-type: none"><li>○ Biochemical evidence of cholestasis based on ALP elevation</li><li>○ Presence of AMA or other PBC-specific autoantibodies</li><li>○ Histology confirmation after biopsy</li></ul></li><li>• Documentation of at least 12 months of inadequate response to ursodiol</li><li>• No current decompensated cirrhosis</li></ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist or gastroenterologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> up to 12 months.
<b>Renewal Criteria</b>	Documented adherence to medication regimen and clinical benefit
<b>Effective Date</b>	01/01/2025
<b>P&amp;T Approval Date</b>	11/12/2024
<b>P&amp;T Revision Date</b>	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 arterial 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/m<sup>2</sup>
- 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

<b>Criteria Details</b>	
	<ul style="list-style-type: none"> <li>• Used in as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)</li> <li>• Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product</li> <li>• Wegovy is not being used in combination with resmetirom</li> </ul>
<b>Exclusions</b>	<ul style="list-style-type: none"> <li>• Weight loss is excluded from coverage</li> </ul>
<b>Prescriber Restrictions</b>	<p><b>Reduction of Major Adverse Cardiovascular Events</b> Prescribed by or in consultation with a cardiologist</p> <p><b>Metabolic Dysfunction-Associated Steatohepatitis (MASH)</b> Prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Endocrinologist</p>
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<p><b>Reduction of Major Adverse Cardiovascular Events</b></p> <ul style="list-style-type: none"> <li>• Member is currently on a maintenance dose of 1.7mg or 2.4mg</li> <li>• Documentation of continuation of lifestyle modification program with reduced calorie diet and regular physical activity alongside continuous Wegovy use (80% adherence)</li> <li>• Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product</li> </ul> <p><b>Metabolic Dysfunction-Associated Steatohepatitis (MASH)</b></p> <ul style="list-style-type: none"> <li>• 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 <math>\geq</math> 25%, MRE <math>\geq</math> 20%, etc.], etc.)</li> <li>• Patient has not progressed to cirrhosis</li> <li>• Documentation of continuation of lifestyle modification program with reduced calorie diet and regular physical activity alongside continuous Wegovy use (80% adherence)</li> <li>• Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product</li> <li>• Wegovy is not being used in combination with resmetirom</li> </ul>
<b>Effective Date</b>	1/1/2026
<b>P&amp;T Approval Date</b>	5/14/2024
<b>P&amp;T Revision Date</b>	11/11/2025, 5/14/2024

# Sodium Oxybate

## Products Affected

- Sodium Oxybate 500mg/mL

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<p><b><u>Cataplexy and Narcolepsy</u></b></p> <ul style="list-style-type: none"><li>• Confirmation of diagnosis of narcolepsy and cataplexy based on BOTH:<ul style="list-style-type: none"><li>○ Polysomnography</li><li>○ A multiple sleep latency test with cataplexy</li></ul></li><li>• Trial and failure or contraindication to ALL the following<ul style="list-style-type: none"><li>○ SSRI antidepressant (e.g. fluoxetine)</li><li>○ SNRI antidepressant (e.g. venlafaxine or duloxetine)</li><li>○ Tricyclic antidepressant (e.g. clomipramine)</li></ul></li></ul> <p><b><u>Excessive Somnolence due to Narcolepsy</u></b></p> <ul style="list-style-type: none"><li>• Confirmation of diagnosis of narcolepsy based on BOTH:<ul style="list-style-type: none"><li>○ Polysomnography</li><li>○ A multiple sleep latency test</li></ul></li><li>• Baseline documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated tool).</li><li>• Trial and failure or contraindication to ALL the following:<ul style="list-style-type: none"><li>○ Modafinil (maximum recommended/tolerated dose)</li><li>○ At least 2 stimulant medications (amphetamine, methylphenidate, dextroamphetamine, etc.)</li><li>○ Sunosi (maximum recommended/tolerated dose)</li></ul></li></ul>
<b>Age Restrictions</b>	Age ≥7 years old and weight ≥20kg
<b>Prescriber Restrictions</b>	Sleep specialist, Neurologist, Pulmonologist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> 12 months.

### Criteria Details

<b>Renewal Criteria</b>	<ul style="list-style-type: none"><li>• Request for a continued maintenance dose within FDA approved limits based on indication.</li><li>• Documented clinical efficacy and tolerability to therapy compared to baseline (for Epworth Sleepiness scale—improvement of at least 3 points is considered clinically significant).</li></ul>
<b>Effective Date</b>	11/1/2025
<b>P&amp;T Approval Date</b>	9/9/2025
<b>P&amp;T Revision Date</b>	9/9/2025

# Solriamfetol (Sunosi)

## Products Affected

- Sunosi Tablets

## Prior Authorization Criteria

### Criteria Details

#### Required Medical Information

#### **Excessive somnolence secondary to narcolepsy**

- 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

#### **Excessive somnolence secondary to Obstructive Sleep Apnea**

- 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

	<ul style="list-style-type: none"> <li>• Trial and failure, adverse reaction, or contraindication to preferred formulary options               <ul style="list-style-type: none"> <li>○ Modafinil titrated to maximum recommended/tolerated dose</li> <li>○ Methylphenidate titrated to maximum recommended/tolerated dose</li> </ul> </li> </ul>
<b>Age Restrictions</b>	Age 18 and older
<b>Prescriber Restrictions</b>	Sleep specialist, Neurologist, Pulmonologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<p><b><u>Excessive somnolence secondary to narcolepsy</u></b></p> <ul style="list-style-type: none"> <li>• Documentation of blood pressure evaluation in the last 3 months.</li> <li>• 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]).</li> </ul> <p><b><u>Excessive somnolence secondary to Obstructive Sleep Apnea</u></b></p> <ul style="list-style-type: none"> <li>• Documentation of blood pressure evaluation in the last 3 months.</li> <li>• Documentation of adherence to primary OSA treatment (e.g. CPAP).</li> <li>• 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]).</li> </ul>
<b>Effective Date</b>	11/1/2025
<b>P&amp;T Approval Date</b>	9/9/2025
<b>P&amp;T Revision Date</b>	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

<b>Required Medical Information</b>	<p><b>For children:</b> 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 <b>AND</b> 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.</p> <p><b>For adults:</b> 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.</p> <p><b>Adult-onset:</b> 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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.

## Criteria Details

<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Sotatercept (WINREVAIR)

## Products Affected

- WINREVAIR INJECTION

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Pulmonary Arterial Hypertension (PAH):</b> <ul style="list-style-type: none"><li>• Diagnosis of symptomatic PAH (WHO Group 1 PH) confirmed by right heart catheterization.</li><li>• WHO functional class II or III symptoms.</li><li>• On a stable dose of both<ul style="list-style-type: none"><li>○ Endothelin-1 receptor antagonists (ERA) <b>and</b></li><li>○ Phosphodiesterase type 5 inhibitors <b>or</b> guanylate cyclase stimulant</li></ul></li><li>• Current PAH background therapies (ERA, PDE5i, etc.) will be continued unless not tolerated.</li><li>• Baseline platelet count &gt;500,000</li></ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	11/1/2024
<b>P&amp;T Approval Date</b>	9/10/2024
<b>P&amp;T Revision Date</b>	9/10/2024

# Sparsentan (FILSPARI)

## Products Affected

- FILSPARI TAB 200MG
- FILSPARI TAB 400MG

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Primary immunoglobulin A nephropathy:</b> <ul style="list-style-type: none"><li>Urine protein-to-creatinine ratio (UPCR) <math>\geq 1.5</math> and eGFR <math>\geq 30</math> mL/min/1.73 m<sup>2</sup></li><li>Biopsy-verified primary IgA nephropathy</li><li>No history of kidney transplant and not currently receiving dialysis</li></ul> 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
<b>Age Restrictions</b>	18 or older
<b>Prescriber Restrictions</b>	Nephrologist
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Improved or stable kidney function compared to baseline <b>OR</b> reduction in proteinuria
<b>Effective Date</b>	09/01/2023
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	

# Suzetrigine (Journavx)

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## Products Affected

- Journavx tablets

<b>Covered Uses</b>	<ul style="list-style-type: none"> <li>• All Food and Drug Administration (FDA)-approved indications not otherwise excluded by plan design <ul style="list-style-type: none"> <li>○ Acute, moderate to severe pain</li> </ul> </li> </ul>
<b>Required Medical Information and Criteria</b>	<p><b><u>Acute moderate to severe pain</u></b></p> <ul style="list-style-type: none"> <li>• Clinical documentation of post-operative use following one of the following: <ul style="list-style-type: none"> <li>○ Abdominoplasty</li> <li>○ Bunionectomy</li> </ul> </li> <li>• Documentation of one of the following: <ul style="list-style-type: none"> <li>○ Diagnosis of opioid use disorder</li> <li>○ Prescriber has a specific concern for opioid abuse.</li> </ul> </li> </ul>
<b>Renewal Criteria</b>	<ul style="list-style-type: none"> <li>• Not eligible for renewal, patients will need to meet initial criteria with new surgery to be eligible for a new prescription.</li> </ul>
<b>Exclusion Criteria</b>	<ul style="list-style-type: none"> <li>• Use for more than 14 days.</li> <li>• Any use outside of acute post-procedural pain.</li> </ul>
<b>Age Restriction</b>	<ul style="list-style-type: none"> <li>• Age 18 or older.</li> </ul>
<b>Coverage Duration</b>	<ul style="list-style-type: none"> <li>• <b>Acute moderate to severe pain:</b> <ul style="list-style-type: none"> <li>○ Initial: 14 days</li> <li>○ Renewal: N/A</li> </ul> </li> </ul>

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

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

# Tazarotene (AVAGE) (TAZORAC)

## Products Affected

- TAZAROTENE 0.1% CREAM

## Prior Authorization Criteria

### Criteria Details

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

# Terbinafine Hydrochloride (LAMISIL)

## Products Affected

- TERBINAFINE HCL

## Prior Authorization Criteria

### Criteria Details

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

# Tezacaftor/ivacaftor (SYMDEKO)

## Products Affected

- SYMDEKO

## Prior Authorization Criteria

### Criteria Details

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

# Ticagrelor

## Products Affected

- Ticagrelor tablets

## Prior Authorization Criteria

### Criteria Details

<p><b>Required Medical Information</b></p>	<p><b><u>Acute Coronary Syndrome</u></b></p> <ul style="list-style-type: none"> <li>• Member has:             <ul style="list-style-type: none"> <li>○ Either non-ST-elevation acute coronary syndrome (NSTEMI) or ST-elevation myocardial infarction (STEMI) AND</li> <li>○ Has had percutaneous coronary intervention (PCI) AND</li> <li>○ Has a contraindication to prasugrel</li> </ul> </li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• Member has NSTEMI and is treated with medical therapy alone (has not had PCI)</li> </ul> <p><b><u>Minor Ischemic Stroke</u></b></p> <ul style="list-style-type: none"> <li>• Member has had a minor non-cardioembolic ischemic stroke (NIHSS score <math>\leq 5</math>) in the immediate past</li> <li>• Did not receive IV alteplase</li> <li>• Has a reason that clopidogrel can't be used</li> </ul>
<p><b>Age Restrictions</b></p>	<p>18 years of age and older</p>
<p><b>Prescriber Restrictions</b></p>	<ul style="list-style-type: none"> <li>• <b>Acute Coronary Syndrome:</b> Cardiologist</li> <li>• <b>Minor Ischemic Stroke:</b> Cardiologist, Neurologist</li> </ul>
<p><b>Coverage Duration</b></p>	<ul style="list-style-type: none"> <li>• <b>Acute Coronary Syndrome:</b> <ul style="list-style-type: none"> <li>○ Initial: 12 months</li> <li>○ Renewal: 12 months</li> </ul> </li> <li>• <b>Minor Ischemic Stroke:</b> <ul style="list-style-type: none"> <li>○ Initial: 1 month</li> <li>○ Renewal: N/A</li> </ul> </li> </ul>
<p><b>Renewal Criteria</b></p>	<ul style="list-style-type: none"> <li>• <b>Acute Coronary Syndrome:</b> Documentation of positive clinical response to therapy and continued need for treatment</li> </ul>

### Criteria Details

	<ul style="list-style-type: none"><li>• <b>Minor ischemic stroke:</b> Renewal not appropriate</li></ul>
<b>Effective Date</b>	9/1/2025
<b>P&amp;T Approval Date</b>	7/11/2023
<b>P&amp;T Revision Date</b>	7/8/2025, 7/11/2023

# Tobramycin Solution

## Products Affected

- Tobramycin nebulization solution

## Prior Authorization Criteria

### Criteria Details

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

	<p>interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) <b>AND</b> 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] <b>AND</b> 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 <b>AND</b> surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.</p> <p><b>Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy:</b> Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy (i.e., Kymriah [tisagenlecleucel], Yescarta [axicabtagene ciloleucel])</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p><b>RA, SJIA, PJIA, GCA:</b> Prescribed by or in consultation with a rheumatologist.</p> <p><b>SSc-ILD:</b> Prescribed by or in consultation with a pulmonologist or rheumatologist.</p> <p><b>CRS:</b> Prescribed by or in consultation with an oncologist or hematologist</p>
<b>Coverage Duration</b>	<p><b>RA, SJIA, PJIA, GCA, SSc-ILD: Initial:</b> 6 months; <b>Renewal:</b> 12 months</p> <p><b>Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy: Initial:</b> 2 months.</p>
<b>Renewal Criteria</b>	<p><b>RA, PJIA:</b> Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen <b>AND</b> tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline.</p> <p><b>SJIA:</b> Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen <b>AND</b> tender) joint count from baseline, or improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline.</p> <p><b>GCA, SSc-ILD:</b> Documentation of positive clinical response to therapy.</p>
<b>Effective Date</b>	09/01/2024
<b>P&amp;T Approval Date</b>	07/11/2023
<b>P&amp;T Revision Date</b>	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

	<p>therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine sulfasalazine, azathioprine, Corticosteroids (e.g., prednisone, methylprednisolone) <b>AND</b> trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Humira, Simponi) <b>AND</b> patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine).</p> <p><b>Polyarticular Juvenile Idiopathic Arthritis (PJIA):</b> Diagnosis of active polyarticular course juvenile idiopathic arthritis <b>AND</b> trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide <b>AND</b> trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Enbrel, Humira) <b>AND</b> patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine).</p>
<p><b>Age Restrictions</b></p>	<p><b>Solution only</b> One of the following:</p> <ul style="list-style-type: none"> <li>• Pediatric member age 10 or under</li> <li>• Documentation inability of the member to use the preferred tablet formulation</li> </ul>
<p><b>Prescriber Restrictions</b></p>	<p><b>RA, AS, PJIA:</b> Prescribed by or in consultation with a rheumatologist <b>PsA:</b> Prescribed by or in consultation with a dermatologist or rheumatologist <b>UC:</b> Prescribed by or in consultation with a gastroenterologist</p>
<p><b>Coverage Duration</b></p>	<p><b>RA, PsA, AS, PJIA: Initial:</b> 6 months. <b>Renewal</b> 12 months <b>Ulcerative Colitis (UC): Initial:</b> 4 months. <b>Renewal</b> 12 months</p>
<p><b>Renewal Criteria</b></p>	<p><b>RA, PJIA:</b> 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 <b>AND</b> will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p> <p><b>PsA:</b> 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 <b>AND</b> will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p>

## 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).

<b>Effective Date</b>	5/1/2024
<b>P&amp;T Approval Date</b>	3/12/2024
<b>P&amp;T Revision Date</b>	07/11/2023, 01/11/2022

# Toremifene (FARESTON)

## Products Affected

- TOREMIFENE CITRATE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Metastatic breast cancer:</b> Postmenopausal female diagnosed with metastatic breast cancer.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by an oncologist.
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 6 months.
<b>Renewal Criteria</b>	Documentation of no disease progression.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# Tranexamic Acid

## Products Affected

• Tranexamic Acid 650MG TAB

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Hemophilia Diagnosis</b> <ul style="list-style-type: none"><li>• Intending to use for hemorrhage prophylaxis for tooth extraction(s)</li></ul> <b>Abnormal Uterine Bleeding</b> <ul style="list-style-type: none"><li>• Currently using or documented trial and failure or contradiction to ALL the following treatments:<ul style="list-style-type: none"><li>○ Cobombined Oral Contraceptive therapy</li><li>○ Profestin therapy (oral or LM) or Levonogrestrel IUD</li></ul></li><li>• NSAID therapy</li></ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by Hematologist, Hemophilia specialist, Dentist, Gynecologist
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	7/1/2024
<b>P&amp;T Approval Date</b>	5/14/2024
<b>P&amp;T Revision Date</b>	

# Prostacyclin Agonists

## Products Affected

- Orenitram tablets
- Remodulin
- Treprostinil
- Tyvaso

## Prior Authorization Criteria

### Criteria Details

<p><b>Required Medical Information</b></p>	<p><b><u>Pulmonary Arterial Hypertension</u></b></p> <ul style="list-style-type: none"> <li>• Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)</li> <li>• Clinical documentation of WHO functional class III or IV</li> <li>• Evidence of an unfavorable response or intolerance to all of the following: <ul style="list-style-type: none"> <li>○ Phosphodiesterase Type 5 inhibitor (sildenafil, tadalafil)</li> <li>○ Endothelin Receptor Antagonist (ambrisentan, bosentan)</li> <li>○ Combination therapy with a Phosphodiesterase Type 5 inhibitor + Endothelin Receptor Antagonist (ambrisentan + tadalafil)</li> </ul> </li> <li>• The requested medication will be an add on to an already established first line agent or agents (sildenafil, tadalafil, ambrisentan, bosentan)</li> </ul>
<p><b>Age Restrictions</b></p>	<p>Age 16 or older</p>
<p><b>Prescriber Restrictions</b></p>	<ul style="list-style-type: none"> <li>• <b>Pulmonary Arterial Hypertension:</b> Cardiologist or Pulmonologist</li> </ul>
<p><b>Coverage Duration</b></p>	<ul style="list-style-type: none"> <li>• <b>Pulmonary Arterial Hypertension:</b> <ul style="list-style-type: none"> <li>○ Initial: 6 months</li> <li>○ Renewal: 12 months</li> </ul> </li> </ul>
<p><b>Renewal Criteria</b></p>	<p>Documentation of positive clinical response to therapy.</p>
<p><b>Effective Date</b></p>	<p>9/1/2025</p>
<p><b>P&amp;T Approval Date</b></p>	<p>7/13/2021</p>
<p><b>P&amp;T Revision Date</b></p>	<p>7/8/2025, 7/13/2021</p>

# Ubrogепant (UBRELVY)

## Products Affected

- UBRELVY

## Prior Authorization Criteria

### Criteria Details

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

# Umbralisib (UKONIQ)

## Products Affected

- Ukoniq

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Marginal zone lymphoma (MZL):</b> Diagnosis of relapsed or refractory marginal zone lymphoma (MZL) <b>AND</b> must have received a prior therapy that included an anti-CD20 antibody agent  <b>Follicular lymphoma (FL):</b> Must have received at least three prior therapies, including both an anti-CD20 antibody <b>AND</b> an alkylating agent  *Maximum daily dose of 4 tablets
<b>Age Restrictions</b>	18 years of age <b>AND</b> older
<b>Prescriber Restrictions</b>	Prescribed by oncologist
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> up to 12 months.
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	
<b>P&amp;T Approval Date</b>	
<b>P&amp;T Revision Date</b>	

# 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

<b>Age Restrictions</b>	<b>AD:</b> Age 12 or older
<b>Prescriber Restrictions</b>	<p><b>RA, AS, PJIA:</b> Prescribed by or in consultation with a rheumatologist</p> <p><b>PsA:</b> Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist.</p> <p><b>AD:</b> Prescribed by or in consultation with one of the following: Dermatologist or Allergist/Immunologist.</p> <p><b>CD/UC:</b> Prescribed by or in consultation with a gastroenterologist</p>
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	<p><b>RA/PJIA:</b> 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). <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p> <p><b>PsA:</b> 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) <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p> <p><b>AS:</b> 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 <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p> <p><b>AD:</b> 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 <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p>

## Criteria Details

	<p><b>UC:</b> 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 <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p> <p><b>CD:</b> 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 <b>AND</b> Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).</p>
<b>Effective Date</b>	1/1/2026
<b>P&amp;T Approval Date</b>	10/16/2019
<b>P&amp;T Revision Date</b>	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

#### 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

#### Crohn's Disease (CD)

- 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

#### Plaque Psoriasis (PP)

- 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

### **Psoriatic Arthritis (PsA)**

- 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 or 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

### **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**

**PsO/PsA:** 6 and older

#### **Exclusion Criteria**

- Not to be used in combination with other biologics for the same indication.

## Criteria Details

<b>Prescriber Restrictions</b>	<ul style="list-style-type: none"> <li>• <b>Crohn's Disease and Ulcerative Colitis:</b> Gastroenterologist.</li> <li>• <b>Plaque Psoriasis:</b> Dermatologist.</li> <li>• <b>Psoriatic Arthritis:</b> Dermatologist or Rheumatologist.</li> </ul>
<b>Coverage Duration</b>	<b>Initial:</b> 6 months. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<ul style="list-style-type: none"> <li>• <b>CD:</b> Evidence of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission.</li> <li>• <b>PP:</b> 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.</li> <li>• <b>PsA:</b> Evidence of a 20% or greater improvement in tender joint count and swollen joint count.</li> <li>• <b>UC:</b> Evidence of a significant response such as a decrease in bloody stools per day or elimination of signs of toxicity.</li> </ul>
<b>Effective Date</b>	05/01/2025
<b>P&amp;T Approval Date</b>	03/11/2025
<b>P&amp;T Revision Date</b>	3/11/2025, 7/11/2023, 1/11/2022
<b>References</b>	<ul style="list-style-type: none"> <li>• Selarsdi [package insert]. Parsippany, NJ: Teva Pharmaceuticals; 2025.</li> <li>• Yesintek [package insert]. Cambridge, MA: Biocon Biologics; 2024.</li> <li>• Steqeyma [package insert]. Jersey City, NJ: Celltrion USA Inc.; 2024.</li> </ul>

# 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

	<ul style="list-style-type: none"> <li>○ Abnormal lab values (e.g., hemoglobin, ESR, CRP)</li> <li>○ Dependent on, or refractory to, corticosteroids</li> <li>● Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies :             <ul style="list-style-type: none"> <li>○ 6-mercaptopurine</li> <li>○ Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)</li> <li>○ Azathioprine</li> <li>○ Corticosteroids (e.g., prednisone)</li> </ul> </li> <li>● One of the following:             <ul style="list-style-type: none"> <li>○ Trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate*:                 <ul style="list-style-type: none"> <li>▪ Humira (adalimumab), Amjevita, Cyltezo, Hyrimoz, or Brand Adalimumab-adaz</li> <li>▪ Simponi (golimumab)</li> <li>▪ Ustekinumab</li> <li>▪ Rinvoq (upadacitinib)</li> <li>▪ Xeljanz/XR (tofacitinib/ER)</li> </ul> </li> <li>○ For continuation of prior Entyvio therapy, defined as no more than a 45-day gap in therapy</li> </ul> </li> </ul>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in collaboration with a Gastroenterologist
<b>Coverage Duration</b>	<b>Initial:</b> 14 weeks. <b>Renewal:</b> 12 months.
<b>Renewal Criteria</b>	<p><b>Crohn's Disease:</b> Documentation of positive clinical response to therapy as evidenced by at least one of the following:</p> <ul style="list-style-type: none"> <li>• Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline</li> <li>• Reversal of high fecal output state</li> </ul> <p><b>Ulcerative Colitis:</b> Documentation of positive clinical response to therapy as evidenced by at least one of the following:</p> <ul style="list-style-type: none"> <li>• Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline</li> <li>• Reversal of high fecal output state</li> </ul>
<b>Effective Date</b>	5/1/2024

## Criteria Details

<b>P&amp;T Approval Date</b>	3/12/2024
<b>P&amp;T Revision Date</b>	

# Vonoprazan (VOQUEZNA)

## Products Affected

- VOQUEZNA 10MG
- VOQUEZNA 20MG

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Erosive esophagitis-</b> <ul style="list-style-type: none"><li>• Imaging confirmed LA Classification Grade C/D erosive esophagitis AND</li><li>• 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.</li></ul> <b>H.pylori eradication –</b> <ul style="list-style-type: none"><li>• Confirmed H. pylori positive infection AND</li><li>• Documented contraindication, intolerance, or inadequate response to standard first-line therapies for H.pylori infection (e.g. PPI (standard or double dose), clarithromycin, amoxicillin (or metronidazole)) AND</li><li>• Documented contraindication, intolerance, or inadequate response to a quadruple bismuth regimen (e.g. standard twice daily dose PPI, bismuth subsalicylate, tetracycline, metronidazole) AND</li><li>• Co-prescribed in combination with antibiotics.</li></ul>
<b>Age Restrictions</b>	Must be at least 18 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in collaboration with a Gastroenterologist or Infectious Disease specialist
<b>Coverage Duration</b>	<b>Initial healing of erosive esophagitis:</b> 2 months <b>Maintenance of healing of erosive esophagitis:</b> 6 months <b>H. Pylori eradication:</b> 14 days
<b>Renewal Criteria</b>	Renewals past the above timelines are not allowed
<b>Effective Date</b>	03/01/2024
<b>P&amp;T Approval Date</b>	01/09/2024

## Criteria Details

P&T Revision Date	
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# Xanomeline and trospium (COBENFY)

## Products Affected

- COBENFY CAPS

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Schizophrenia:</b> <ul style="list-style-type: none"><li>• Confirmed diagnosis of schizophrenia.</li><li>• Used as monotherapy (not used in combination with 1<sup>st</sup> or 2<sup>nd</sup> generation antipsychotic therapy).</li><li>• 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).</li></ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Psychiatry
<b>Coverage Duration</b>	<b>Initial:</b> 12 months. <b>Renewal:</b> 12 months
<b>Renewal Criteria</b>	Documentation of positive clinical response to therapy.
<b>Effective Date</b>	03/01/2025
<b>P&amp;T Approval Date</b>	01/14/2025
<b>P&amp;T Revision Date</b>	01/14/2025

# Zuranolone (ZURZUVAE)

## Products Affected

- ZURZUVAE

## Prior Authorization Criteria

### Criteria Details

<b>Required Medical Information</b>	<b>Postpartum Depression</b> <ul style="list-style-type: none"><li>• 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</li><li>• 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</li><li>• Patient has tried/failed generic SSRI or SNIR for PPD</li></ul>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by psychiatrist or OB/GYN
<b>Coverage Duration</b>	<b>Initial:</b> 3 months. <b>Renewal:</b> N/A
<b>Renewal Criteria</b>	
<b>Effective Date</b>	7/1/2024
<b>P&amp;T Approval Date</b>	5/14/2024
<b>P&amp;T Revision Date</b>	

