### Tymlos

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
</table>
|        | abaloparatide | **Covered Uses:** Osteoporosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Documentation of a T-score less than -2.5 at the lumbar spine, hip (total hip or femoral neck), or radius (one-third radius site).  
  b. Documented inadequate response (e.g. greater than 3 percent decrease in bone mineral density from baseline, fracture from minimal trauma) while receiving the following, or clinically significant adverse effects to all of the following:  
    i. An oral bisphosphonate (e.g. alendronate)  
    ii. An intravenous bisphosphonate (e.g. zoledronic acid)  
    iii. Prolia  
  c. Patient is concurrently receiving calcium and vitamin D supplement.  
  d. The combined duration of treatment with any parathyroid hormone analogs has not exceeded a lifetime maximum of 24 months (i.e. abaloparatide and teriparatide)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |

### Orencia

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Orenica</td>
<td>abatacept</td>
<td><strong>Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</strong></td>
</tr>
</tbody>
</table>

### Verzenio

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<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Verzenio</td>
<td>abemaciclib</td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
</tr>
</tbody>
</table>

### Dyson (abiraterone)

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<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Dyson</td>
<td>abiraterone</td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
</tr>
</tbody>
</table>

### Dysport

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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Dysport</td>
<td>abobotulinum toxin A</td>
<td><strong>Please refer to Botulinum Toxin Drug Class Prior Authorization Criteria</strong></td>
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</tbody>
</table>

### Acyclovir 5% topical cream

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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
</table>
| Acyclovir 5% topical cream | | **Covered Uses:** Herpes labialis or herpes febrilis (cold sore)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement: |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
|                | acyclovir topical ointment       | Covered Uses: Must meet “1” of the following  
|                |                                  |   a. Genital herpes simplex virus infection (HSV)  
|                |                                  |   b. Non-life threatening mucocutaneous herpes simplex virus infection, patient immunocompromised  
|                |                                  | Exclusion Criteria: N/A  
|                |                                  | Required Medical Information: Must meet the following requirement:  
|                |                                  |   a. Failure or clinically significant adverse effects to “1” of the alternatives: acyclovir tablet, famciclovir tablet or valacyclovir tablet  
|                |                                  | Age Restrictions: N/A  
|                |                                  | Prescriber Restrictions: N/A  
| Humira         | adapalene topical                | Covered Uses: Acne vulgaris (acne)  
|                |                                  | Exclusion Criteria: N/A  
|                |                                  | Required Medical Information: Must meet all of the following requirements:  
|                |                                  |   a. Failure or clinically significant adverse effects to “1” of the following: tretinoin cream OR tretinoin gel  
|                |                                  |   b. Failure or clinically significant adverse effects to “2” of the following: benzoyl peroxide topical, clindamycin topical or erythromycin topical  
|                |                                  | Age Restrictions: N/A  
|                |                                  | Prescriber Restrictions: Dermatologist  
| Epiduo, Epiduo Forte | adapalene, benzoyl peroxide | Covered Uses: Acne vulgaris (acne)  
|                |                                  | Exclusion Criteria: N/A  
|                |                                  | Required Medical Information: Must meet all of the following requirements:  
|                |                                  |   a. Failure or clinically significant adverse effects to ALL of the following: benzoyl peroxide topical AND tretinoin topical  
|                |                                  |   b. Failure or clinically significant adverse effects to “1” of the following: clindamycin topical or erythromycin topical  
|                |                                  | Age Restrictions: N/A  
|                |                                  | Prescriber Restrictions: Dermatologist  
| Kadcyla        | ado-trastuzumab emtansine        | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria  
| Gilotrif       | afatinib                         | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria  
| Eylea          | aflibercept                      | Covered Uses: Neovascular (Wet) Age related macular degeneration, Macular edema with retinal vein occlusion, Diabetic macular edema OR Diabetic retinopathy  
|                |                                  | Exclusion Criteria: N/A  

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<td></td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: Ophthalmologist</td>
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<tr>
<td>albendazole</td>
<td></td>
<td><strong>Covered Uses</strong>: Must meet “1” of the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. Neurocysticercosis caused by pork tapeworm, <em>Taenia solium</em></td>
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<td></td>
<td></td>
<td>b. Cystic hydatid disease of the liver, lung, and peritoneum, cased by the</td>
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<td></td>
<td></td>
<td><em>Echinococcus granulosus</em></td>
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<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<td></td>
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<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td>Proair HFA</td>
<td>albuterol</td>
<td><strong>Covered Uses</strong>: Bronchospasm or Prevention of exercise-induced bronchospasm</td>
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<tr>
<td>Proair Respiclick</td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to the following:</td>
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<td></td>
<td></td>
<td>albuterol sulfate HFA or <em>Ventolin</em></td>
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<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td>Proventil HFA</td>
<td>albuterol</td>
<td><strong>Covered Uses</strong>: Bronchospasm or Prevention of exercise-induced bronchospasm</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<tr>
<td></td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to the following:</td>
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<tr>
<td></td>
<td></td>
<td>albuterol sulfate HFA or <em>Ventolin</em></td>
</tr>
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<td></td>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td>albuterol tablet</td>
<td><strong>Covered Uses</strong>: Bronchospasm</td>
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<td></td>
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<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to “1” of the</td>
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<td>following: albuterol ER tablet or albuterol syrup</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Covered Uses</td>
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| Lastacaft | alcaftadine ophthalmic solution | Allergic conjunctivitis                          | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
  a. Failure or clinically significant adverse effects to "2" of the following: azelastine, cromolyn, olopatadine, or Zaditor  
  b. Prescribed by an Ophthalmologist or Optometrist  
**Prescriber Restrictions:** See Required Medical Information |
| Alecensa  | alectinib                | Relapsing form of multiple sclerosis           | **Exclusion Criteria:** Member with HIV infection  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to all of the following:  
    i. One glatiramer product (glatiramer or Glatopa)  
    ii. One interferon alternative: Avonex Betaseron, Extavia, Rebif, Rebif Rebishde or Plegridy;  
    iii. One oral disease modifying therapy: Aubago, Gilnya or Tecfidera;  
  b. Ineffectiveness of above therapy is evidenced by "1" of the following:  
    i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
    ii. Member continues to have CNS lesion progression as shown in MRI;  
    iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.);  
  c. Documentation of premedication with corticosteroids  
  d. Documentation of herpes prophylaxis.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Lemtrada  | alemtuzumab             | Benign prostatic hyperplasia                    | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the alternatives: doxazosin, finasteride, prazosin OR tamsulosin  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Urologist |
| Praluent  | alirocumab injection    | Migraine headache                               | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to "1" of the following: rizatriptan or rizatriptan ODT  
  b. Failure or clinically significant adverse effects to the following: sumatriptan  

Please refer to Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor Drug Class Prior Authorization Criteria
<table>
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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
</table>
| Letairis    | ambrisentan       | **Covered Uses:** Pulmonary Arterial Hypertension  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documented WHO Functional Class II or above  
b. Failure or clinically significant adverse effect to sildenafil  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Cardiologist, Pulmonologist |
| Adzenys ER  | amphetamine       | **Covered Uses:** ADHD  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia)  
i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA  
b. Failure or clinically significant adverse effects to at least two formulary long-acting stimulants: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Adzenys XR ODT | amphetamine ER dispersible tablet | **Covered Uses:** ADHD  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia)  
i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA  
b. Failure or clinically significant adverse effects to at least two formulary long-acting stimulants: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Dyanavel XR | amphetamine ER suspension | **Covered Uses:** ADHD  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia)  
i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA  
b. Failure or clinically significant adverse effects to at least two formulary long-acting stimulants: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
</table>
|            | dexamethylphenidate ER   | *Criteria:* Must meet "1" of the following:  
a. ADHD  
b. Narcolepsy  
*Exclusion Criteria:* N/A  
*Required Medical Information:* Must meet the following requirement:  
a. Failure or clinically adverse effects to at least two formulary stimulants: dexmethyllphenidate, dexamethylphenidate ER, dextroamphetamine, dextroamphetamine ER, dextroamp-amphet, dextroam-p-amphet ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* N/A  

| amphetamine sulfate | Covered Uses: Must meet "1" of the following:  
a. ADHD  
b. Narcolepsy  
*Exclusion Criteria:* N/A  
*Required Medical Information:* Must meet the following requirement:  
a. Failure or clinically adverse effects to at least two formulary stimulants: dexmethylphenidate, dexamethylphenidate ER, dextroamphetamine, dextroamphetamine ER, dextroamp-amphet, dextroamp-amphet ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* N/A  

|            | obex               | Covered Uses: Obesity  
*Exclusion Criteria:* N/A  
*Required Medical Information:* Must meet all of the following:  
a. Must meet BMI Required Medical Information (please see the anti-obesity drug class prior authorization protocol); AND  
b. Failure or clinically adverse effects to orlistat, phentermine and diethylpropion  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* N/A  

|            | apicilln, sulbactam | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria  

| Kineret    | anakinra             | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria  

| Erleada    | apalutamide          | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria  

| Eliquis    | apixaban             | Code 1 Criteria: Deep Venous Thrombosis (DVT) and/or Pulmonary Embolism (PE)  
Code 1 Criteria: Prophylaxis DVT following hip or knee replacement surgery  
*Covered Uses:* Non-Valvular Atrial Fibrillation (AFib)  
*Exclusion Criteria:* N/A  
*Required Medical Information:* Must meet the following requirement:  
a. Failure or clinically significant adverse effects to warfarin.  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* N/A  


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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
| Iopidine 1% | apraclonidine | **Covered Uses**: Open-angle glaucoma or ocular hypertension  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure clinically significant adverse effects to the following: brimonidine 0.2%  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| Otezla      | apremilast    | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria                                                                                                              |
| Brovana     | arformoterol  | **Covered Uses**: Chronic obstructive pulmonary disease (COPD): chronic bronchitis or emphysema  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the following: Serevent  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
|             | armodafinil   | **Covered Uses**: Must meet “1“ of the following:  
a. Narcolepsy  
b. Obstructive Sleep Apnea  
c. Shift work disorder  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the alternative: modafinil  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Neurologist, Psychiatrist, Sleep Medicine specialist |
|             | arsenic trioxide | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                                                                           |
| Erwinaze    | asparaginase erwinia chrysanthemi | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                                                                           |
| Inlyta      | axitinib      | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                                                                           |
| Dymista     | azelastine, fluticasone | **Covered Uses**: Allergic rhinitis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to all of the following: azelastine nasal, fluticasone propionate spray and Nasacort spray |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Age Restrictions: Must be age of 6 years or older</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Prescriber Restrictions: N/A</td>
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<tr>
<td>AzaSite</td>
<td>azithromycin ophthalmic drops</td>
<td>Covered Uses: Bacterial conjunctivitis</td>
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<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information:</td>
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<td>Must meet &quot;1&quot; of the following:</td>
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<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: Ciloxan 0.3% ointment, ciprofloxacin 0.3 % drops, erythromycin ointment, Gentak ointment, gentamicin drops, levofloxacin 0.5 % drops, neomycin-polymyxin-gramicidin drops, neomycin-polymyxin-B-dexameth oint, neomycin-polymyxin-hydrocort drop, neomycin-bacitracin-polymyxin oint, neomycin-polymyxin-dexameth drops, ofloxacin 0.3 % drops, polymyxin B sulfate-trimethoprim drops, sulfacetamide 10 % drops, sulfacetamide 10 % ointment, sulfacetamide-prednisolone drops, TobraDex ointment, tobramycin 0.3 % drops, tobramycin-dexamethasone drops, Tobrex 0.3 % ointment or Vigamox 0.5 % drops</td>
<td>Age Restrictions: N/A</td>
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<td>b. Prescribed by a specialist (e.g. Infectious Disease specialist, Ophthalmologist, Optometrist)</td>
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<td>Prescriber Restrictions: See Required Medical Information</td>
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<tr>
<td>Regranex</td>
<td>becaplermin</td>
<td>Covered Uses: Diabetic ulcers (lower extremity)</td>
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<td>Age Restrictions: N/A</td>
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<td></td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information:</td>
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<td>Must meet all of the following:</td>
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<td></td>
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<td>a. Documentation that the ulcer extends into the subcutaneous tissue or beyond with adequate blood supply</td>
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<td>b. Failure or clinically significant adverse effects to at least 4 weeks of conventional therapies: debridement, pressure relief, infection control-including antibiotic therapy, adequate nutrition OR diabetes control</td>
<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: N/A</td>
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<tr>
<td>Beconase AQ</td>
<td>beclomethasone intranasal</td>
<td>Covered Uses: Allergic rhinitis</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information:</td>
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<td>Must meet all of the following:</td>
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<td>a. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and Nasacort spray</td>
<td>Age Restrictions: N/A</td>
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<td>b. Failure or clinically significant adverse effects to &quot;1&quot; of the following: cetrizine or loratadine</td>
<td>Prescriber Restrictions: N/A</td>
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<td></td>
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<td>Covered Uses: Nasal polyp</td>
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<td>Age Restrictions: Must be age of 6 years or older</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information:</td>
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<td>Must meet the following requirement:</td>
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<td>a. Confirmed diagnosis</td>
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<td>Age Restrictions:</td>
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<td>Prescriber Restrictions: N/A</td>
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<td>Brand</td>
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<td>Covered Uses</td>
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| Qnasl     | beclomethasone intranasal   | Covered Uses: Allergic rhinitis | Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and Nasacort spray  
b. Failure of clinically significant adverse effects to "1" of the following: cetirizine or loratadine  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Benlysta  | belimumab                   | Covered Uses: Systemic Lupus Erythematosus | Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet all of the following requirements:  
a. Documented positive SLE autoantibody as evidenced by "1" of the following:  
i. Antinuclear antibody (ANA) positive;  
ii. Anti-double stranded DNA (anti-dsDNA) positive  
b. Documentation of functional impairment that limits daily living activities;  
c. Failure or clinically significant adverse effects to daily oral corticosteroids (e.g. prednisone);  
d. Failure or clinically significant adverse effects to "2" of the following: chloroquine, hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide OR mycophenolate;  
Age Restrictions: N/A  
Prescriber Restrictions: Rheumatologist, Immunologist |
| Beleodaq  | belinostat                  | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
|          | bendamustine                | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
|          | bendamustine                | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Bepreve   | bepotastine                 | Covered Uses: Allergic conjunctivitis | Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
a. Failure or clinically significant adverse effects to "2" of the following: azelastine, cromolyn, olopatadine, or Zaditor  
b. Prescribed by an Ophthalmologist or Optometrist  
Prescriber Restrictions: See Required Medical Information |
| Besivance | besifloxacin ophthalmic suspension | Covered Uses: Bacterial conjunctivitis | Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following:  
a. Failure or clinically significant adverse effects to "2" of the following: Ciloxan 0.3% ointment, ciprofloxacin 0.3 % drops, erythromycin ointment, Gentak ointment, gentamicin drops, levofloxacin 0.5 % drops, neomycin-polymyxin-gramicidin |
<table>
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<th>Brand</th>
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<td><strong>d.</strong> Drops, neomycin-polymyxin B-dexameth oint, neomycin-polymyxin-hydrocort drop, neomycin-bacitracin-polymyxin oint, neomycin-polymyxin-dexameth drops, ofloxacin 0.3 % drops, polymyxin B sulfate-trimethoprim drops, sulfacetamide 10 % drops, sulfacetamide 10 % ointment, sulfacetamide-prednisolone drops, TobraDex ointment, tobramycin 0.3 % drops, tobramycin-dexamethasone drops, Tobrex 0.3 % ointment or Vigamox 0.5 % drops</td>
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<td><strong>b.</strong> Prescribed by a specialist (e.g. Infectious Disease specialist, Ophthalmologist, Optometrist)</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> See Required Medical Information</td>
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<tr>
<td>Betoptic-S</td>
<td>betaxolol 0.25%</td>
<td><strong>Covered Uses:</strong> Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement: a. Failure or clinically significant adverse effects to “2” of the following: levobunolol, metipranolol or timolol</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td>betaxolol 0.5%</td>
<td><strong>Covered Uses:</strong> Open-angle glaucoma or ocular hypertension</td>
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<td></td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement: a. Failure or clinically significant adverse effects to “2” of the following: levobunolol, metipranolol or timolol</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Avastin (Ocular)</td>
<td>bevacizumab</td>
<td><strong>Covered Uses:</strong> Age related macular degeneration, Macular edema with retinal vein occlusion, Choroidal retinal neovascularization, Diabetic macular edema OR Diabetic retinopathy</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement: a. Confirmed diagnosis</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
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<td><strong>Prescriber Restrictions:</strong> Ophthalmologist</td>
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<tr>
<td>Avastin (Oncology)</td>
<td>bevacizumab vial</td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
</tr>
<tr>
<td>Lumigan</td>
<td>bimatoprost</td>
<td><strong>Covered Uses:</strong> Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement: a. Failure or clinically significant adverse effects to the following: latanoprost</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td>bortezomib</td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Covered Uses:</td>
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<tr>
<td>Tracleer</td>
<td>bosentan</td>
<td>Pulmonary Arterial Hypertension</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<td>a. Documented WHO Functional Class II or above</td>
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<td>b. Failure or clinically significant adverse effect to sildenafil</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
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<tr>
<td>Bosulif</td>
<td>bosutinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Alphagan P</td>
<td>brimonidine 0.1%</td>
<td>Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to the following: brimonidine 0.2%</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td>brimonidine 0.15%</td>
<td>Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to the following: brimonidine 0.2%</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Combigan</td>
<td>brimonidine tartrate, timolol maleate</td>
<td>Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to all of the following: brimonidine 0.2% and timolol</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Azopt</td>
<td>brinzolamide</td>
<td>Open-angle glaucoma or ocular hypertension</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to the following: dorzolamide</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Brand</td>
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<td>Covered Uses</td>
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| Simbrinza   | brinzolamide, brimonidine| Open-angle glaucoma or ocular hypertension                                                               | Required Medical Information: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to all of the following: brimonidine 0.2% and dorzolamide  
  Age Restrictions: N/A  
  Prescriber Restrictions: N/A                                                                                                                                                                                                                                               |
| Briviact    | brivaracetam             | Seizure (i.e. partial-onset seizure)                                                                     | Required Medical Information: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the alternatives: carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate or zonisamide.  
  Age Restrictions: N/A  
  Prescriber Restrictions: Neurologist (new start)                                                                                                                                                                                                                             |
|             | budesonide ER 3mg capsule| Crohn's disease                                                                                         | Exclusion Criteria: N/A  
  Required Medical Information: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "1" of the alternatives: dexamethasone, hydrocortisone, methylprednisolone, prednisone OR prednisolone  
  Age Restrictions: N/A  
  Prescriber Restrictions: Gastroenterologist                                                                                                                                                                                                                                                                                         |
|             | budesonide ER 9mg tablet | Ulcerative Colitis                                                                                     | Exclusion Criteria: N/A  
  Required Medical Information: Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to "1" of the alternatives: balsalazide OR sulfasalazine  
  b. Failure or clinically significant adverse effects to "1" of the alternatives: dexamethasone, hydrocortisone, methylprednisolone, prednisone OR prednisolone  
  Age Restrictions: N/A  
  Prescriber Restrictions: Gastroenterologist                                                                                                                                                                                                                                                                                         |
|             | budesonide intranasal    | Allergic rhinitis                                                                                       | Exclusion Criteria: N/A  
  Required Medical Information: Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and Nasacort spray  
  b. Failure of clinically significant adverse effects to "1" of the following: cetirizine or loratadine  
  Age Restrictions: N/A  
  Prescriber Restrictions: N/A  
  Covered Uses: Nasal polyp  
  Exclusion Criteria: N/A  
  Covered Uses: Nasal polyp
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| Symbicort | budesonide, formoterol | **Covered Uses:** Asthma  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet “1” of the “3” requirements:  
- **a.** Ages 5-11  
  - i. Failure or clinically significant adverse effects to two formulary inhaled corticosteroids: Asmanex, Flovent, Pulmicort or Qvar  
- **b.** Ages 12-17  
  - i. Failure or clinically significant adverse effects to formulary fluticasone/salmeterol inhaler or AirDuo  
- **c.** Ages 18 and older  
  - i. Must meet “1” of the following requirements:  
    - Failure or clinically significant adverse effects to two formulary inhaled corticosteroids: Asmanex, Flovent, Pulmicort or Qvar  
    - At least one asthma exacerbation in the last year (12 months)  
**Age Restriction:** Must be of age 5 years and older  
**Prescriber Restrictions:** N/A |
| Aplenzin | bupropion | **Covered Uses:** Major depressive disorder  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following:  
- **a.** Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary bupropion  
- **b.** Failure or clinically significant adverse effects to at least a 6-week treatment course of one additional formulary antidepressant alternative: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER or mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Psychiatrist |
| | bupropion 450mg ER | **Covered Uses:** Major depressive disorder  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
- **a.** Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary bupropion |
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<td>b. Failure or clinically significant adverse effects to at least a 6-week treatment course of &quot;1&quot; additional formulary antidepressant alternatives: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER OR mirtazapine&lt;br&gt;Age Restrictions: N/A&lt;br&gt;Prescriber Restrictions: Psychiatrist</td>
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<td>butalbital, acetaminophen, caffeine 50-300-40 capsule</td>
<td>Covered Uses: Tension or muscle contraction headache&lt;br&gt;Exclusion Criteria: N/A&lt;br&gt;Required Medical Information: Must meet the following requirement:&lt;br&gt;a. Failure or clinically significant adverse effects to the alternative: butalbital-acetaminophen-caffeine (50/325/40mg)&lt;br&gt;Age Restrictions: N/A&lt;br&gt;Prescriber Restrictions: N/A</td>
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<tr>
<td>Berinert</td>
<td>C1 esterase inhibitor</td>
<td>Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Cinryze</td>
<td>C1 esterase inhibitor</td>
<td>Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Haegarda</td>
<td>C1 esterase inhibitor</td>
<td>Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Ruconest</td>
<td>C1 esterase inhibitor, recombinant</td>
<td>Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Jevtana</td>
<td>cabazitaxel</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
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<td>cabergoline</td>
<td>Covered Uses: Prolactinoma or Hyperprolactinemia&lt;br&gt;Exclusion Criteria: N/A&lt;br&gt;Required Medical Information: Must meet the following requirement:&lt;br&gt;a. Confirmed diagnosis&lt;br&gt;Age Restrictions: N/A&lt;br&gt;Prescriber Restrictions: N/A</td>
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<tr>
<td>Cabometyx</td>
<td>cabozantinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Cometriq</td>
<td>cabozantinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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|       | calcipotriene topical | Covered Uses: Plaque psoriasis<br>Exclusion Criteria: N/A<br>Required Medical Information: Must meet the following requirement:
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<th>Generic</th>
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| Phoslyra | calcium acetate solution | a. Failure or clinically significant adverse effects to "2" of the alternatives: betamethasone dipropionate 0.05% (lotion, ointment, cream), betamethasone valerate 0.1% (ointment, cream), clobetasol 0.05% (ointment, cream, foam, gel, solution), clobetasol-emollient 0.05 % topical cream, fluocinolone 0.025% (cream, ointment), fluocinonide 0.05% (cream, gel, ointment, solution), Fluocinonide-E 0.05 % topical cream, mometasone 0.1% (ointment, cream, solution), triamcinolone 0.1% (cream, ointment, lotion), OR triamcinolone 0.5% (ointment, cream)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Dermatologist |
| Rytary | carbidopa, levodopa ER capsule | **Covered Uses:** Parkinson’s disease  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documented motor complications (e.g. wearing off phenomenon, freezing of gait, lack of the “on” response, etc.) associated with advanced Parkinson OR mean off time greater than or equal to 2.5 hours/day  
b. Failure or clinically significant adverse effects to formulary carbidopa-levodopa or carbidopa-levodopa ER  
c. Failure or clinically significant adverse effects to formulary entacapone  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Kyprolis | carfilzomib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| | carisoprodol | **Covered Uses:** Treatment of acute, painful musculoskeletal condition (e.g. neck pain, low back pain)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "2" of the following: cyclobenzaprine, methocarbamol or tizanidine  
b. Must not have history of taking concurrently with an opioid (e.g. hydrocodone/APAP, oxycodone) AND a benzodiazepine (e.g. alprazolam) (i.e. Three drug combination) within the past month  
c. Limit to short-term use only (i.e. no more than 1 month) |
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|       |         | **Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|       |         | **Covered Uses:** Open-angle glaucoma or ocular hypertension  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: levobunolol, metipranolol or timolol  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| carteolol |         | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| cefepime |         | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| cefotaxime |         | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| Teflaro | ceftaroline fosamil (IV) | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| cefazidime |         | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| ceftriaxone |         | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
|       |         | **Covered Uses:** Must meet "1" of the following:  
a. Ankylosing spondylitis  
b. Osteoarthritis (OA)  
c. Primary dysmenorrhea (i.e. menstrual pain)  
d. Rheumatoid arthritis (RA)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Step therapy: Trial of two formulary NSAIDs  
b. Request may be granted if there is medical justification why member cannot use NSAIDs (e.g. GI history, concurrent oral anticoagulant, concurrent systemic corticosteroids, high risk for bleed, etc.)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
**Covered Uses:** Acute pain  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Step therapy: Trial of two formulary NSAIDs  
b. Request may be granted if there is medical justification why member cannot use NSAIDs (e.g. GI history, concurrent oral anticoagulant, concurrent systemic corticosteroids, high risk for bleed, etc.) |
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<tr>
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<tbody>
<tr>
<td>Zykadia</td>
<td>ceritinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Cimzia</td>
<td>certolizumab</td>
<td>Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Erbitux</td>
<td>cetuximab</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
|         | cevimeline | Covered Uses: Xerostomia associated with Sjogren’s syndrome  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the following: pilocarpine tablet  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|         | chlordiazepoxide | Covered Uses: Anxiety  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: alprazolam, clonazepam, diazepam OR lorazepam  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|         | chlorzoxazone | Covered Uses: Treatment of acute, painful musculoskeletal condition (e.g. neck pain, low back pain)  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: cyclobenzaprine, methocarbamol OR tizanidine  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Omnaris | ciclesonide | Covered Uses: Allergic rhinitis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements: |
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
| Zetonna       | ciclesonide                                | **Covered Uses:** Allergic rhinitis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and triamcinolone spray  
  b. Failure of clinically significant adverse effects to "1" of the following: cetirizine or loratadine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A                                                                                                                                                                                                 |
|               | ciclopirox topical                         | **Covered Uses:** Tinea, superficial (e.g. Tinea pedis, Tinea corporis, Tinea cruris, Tinea versicolor)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to "1" of the following: clotrimazole cream, clotrimazole solution, clotrimazole-betamethasone cream, clotrimazole-betamethasone lotion, econazole nitrate cream or ketoconazole cream  
  b. Failure or clinically significant adverse effects to "1" of the following: terbinafine cream or tolnaftate topical  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A                                                                                                                                                                                                 |
|               | clindamycin phosphate, benzoyl peroxide topical gel | **Covered Uses:** Acne vulgaris (acne)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to ALL of the following: benzoyl peroxide topical AND clindamycin topical  
  b. Failure or clinically significant adverse effects to "1" of the following: erythromycin topical or tretinoin topical  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Dermatologist                                                                                                                                                                                                 |
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
</tr>
</thead>
</table>
| clobazam | clobazam | Seizure | N/A | Must meet the following requirement:  
  a. Must use concurrently with at least "1" other anticonvulsant medication | N/A | Neurologist (new start) |
| clomipramine | clomipramine | Obsessive-compulsive disorder | N/A | Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the alternatives: fluoxetine, paroxetine OR sertraline | N/A | Mental Health specialist, Psychiatrist |
| clorazepate | clorazepate | Anxiety | N/A | Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the alternatives: alprazolam, buspirone, clonazepam, diazepam, hydroxyzine OR lorazepam | N/A | N/A |
|  |  |  |  | Covered Uses: Must meet "1" of the following:  
  a. Ethanol withdrawal  
  b. Seizures | N/A | N/A |
| Cotellic | cobimetinib |  |  | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |  |  |
| Santyl | collagenase | Burn, debridement of severe burn, Chronic skin ulcer | N/A | Covered Uses: Must meet "1" of the following:  
  a. Burn, debridement of severe burn  
  b. Chronic skin ulcer | N/A | N/A |
|  |  | Must meet "1" of the following requirements:  
  a. Requested quantity is within quantity limit  
  b. For quantity greater than quantity limit  
    i. Documentation of the size of the wound and the duration of therapy  
    ii. Use Santyl calculator to calculate the approximate quantity for approval |  |  |  |  |
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>H.P. Acthar Gel</td>
<td>corticotropin</td>
<td>Please refer to H.P. Acthar Gel Drug Prior Authorization Criteria</td>
</tr>
<tr>
<td>Eucrisa</td>
<td>crisaborole</td>
<td><strong>Covered Uses:</strong> Atopic dermatitis (i.e. eczema)</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<td></td>
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<td>a. Failure or clinically significant adverse effects to “2” of the alternatives: betamethasone dipropionate 0.05% (lotion, ointment, cream), betamethasone valerate 0.1% (ointment, cream), clobetasol 0.05% (ointment, cream, foam, gel, solution), clobetasol-emollient 0.05 % topical cream, fluocinolone 0.025% (cream, ointment), fluocinonide 0.05% (cream, gel, ointment, solution), Fluocinonide-E 0.05 % topical cream, mometasone 0.1% (ointment, cream, solution), triamcinolone 0.1% (cream, ointment, lotion), OR triamcinolone 0.5% (ointment, cream)</td>
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<td>b. Failure or clinically significant adverse effects to the alternative: tacrolimus ointment</td>
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<tr>
<td>Xalkori</td>
<td>crizotinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Amrix ER</td>
<td>cyclobenzaprine ER</td>
<td><strong>Covered Uses:</strong> Treatment of acute, painful musculoskeletal condition (e.g. neck pain, low back pain)</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to “2” of the following: cyclobenzaprine, methocarbamol or tizanidine</td>
</tr>
<tr>
<td>Restasis</td>
<td>cyclosporine</td>
<td><strong>Covered Uses:</strong> Keratoconjunctivitis sicca</td>
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<td></td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
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<td>a. Failure or clinically significant adverse effects to “1” of the following: Artificial tears, For Sty Relief, GenTeal, Isopto tear, lubricant eye drops/ointment, polyvinyl alcohol, Pure &amp; Gentle eye drops, Refresh, Systane nighttime eye ointment, Retaine PM eye ointment or Tears Naturale Forte eye drops</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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</tbody>
</table>
|        |         | **Age Restrictions:** N/A  
**Prescriber Restrictions:** Ophthalmologist, Optometrist |
| Tafinlar dabrafenib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Daklinza daclatasvir | Please refer to the Hepatitis C Drug Class Criteria |
| dalfampridine or 4-aminopyridine | **Covered Uses:** Multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Documentation that member has the ability to ambulate at least 25 feet within 8 to 45 seconds;  
b. Documented significant limitation of daily activities (e.g. meal preparation, household chores, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| dantrolene | **Covered Uses:** Chronic spasticity  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "1" of the following: baclofen or tizanidine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
**Covered Uses:** Malignant hyperthermia: treatment or prevention  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
<p>| daptomycin | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| Darzalex daratumumab | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Aranesp darbepoetin | Please refer to Erythropoiesis-Stimulating Agents (ESAs) Drug Class Prior Authorization Criteria |
| Viekira XR dasabuvir, ombitasvir, | Please refer to the Hepatitis C Drug Class Criteria |</p>
<table>
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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Sprycel</td>
<td>dasatinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<thead>
<tr>
<th>Exjade</th>
<th>deferasirox</th>
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</table>
| Covered Uses: Chronic iron overload due to blood transfusions  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet all of the following requirements:  
a. Must meet "1" of the following:  
   i. Documented baseline serum ferritin greater than 1000 mcg/L  
   ii. Documentation of Liver Iron Concentration (LIC) greater than 7 mg/g dw  
b. Documentation of blood transfusions  
Age Restriction: N/A  
Prescriber Restrictions: Hematologist |

<table>
<thead>
<tr>
<th>Jadenu</th>
<th>deferasirox</th>
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</thead>
</table>
| Covered Uses: Chronic iron overload due to blood transfusions  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet "1" of the following requirements:  
a. Must meet "1" of the following:  
   i. Documented baseline serum ferritin greater than 1000 mcg/L  
   ii. Documentation of Liver Iron Concentration (LIC) greater than 7 mg/g dw  
b. Documentation of blood transfusions  
Age Restriction: N/A  
Prescriber Restrictions: Hematologist |

Covered Uses: Chronic iron overload due to non-transfusion dependent thalassemia  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet "1" of the following requirements:  
a. Documented baseline serum ferritin greater than 300 mcg/L  
b. Documentation of Liver Iron Concentration (LIC) greater than 5 mg/g dw  
Age Restriction: N/A  
Prescriber Restrictions: Hematologist |
<table>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
| Ferriprox | deferiprone| **Covered Uses**: Chronic iron overload due to transfusion, thalassemia syndromes  
**Exclusion Criteria**: CCS eligible  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Must meet "1" of the following:  
     i. Documented baseline serum ferritin greater than 1000 mcg/L  
     ii. Documentation of Liver Iron Concentration (LIC) greater than 7 mg/g dw  
  b. Documentation of blood transfusions  
  c. Failure or clinically significant adverse effects to "1" of the following: deferoxamine, Exjade OR Jadenu  
**Age Restriction**: N/A  
**Prescriber Restrictions**: Hematologist |
|          | deferoxamine| **Covered Uses**: Chronic iron overload due to blood transfusions  
**Exclusion Criteria**: CCS eligible  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Must meet "1" of the following requirements:  
     i. Documented baseline serum ferritin greater than 1000 mcg/L  
     ii. Documentation of Liver Iron Concentration (LIC) greater than 7 mg/g dw  
  b. Documentation of blood transfusions  
**Age Restriction**: N/A  
**Prescriber Restrictions**: Hematologist  
**Covered Uses**: Acute iron toxicity  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Confirmed diagnosis (considered medical emergency that requires hospitalization/ED)  
**Age Restriction**: N/A  
**Prescriber Restrictions**: N/A |
| Firmagon  | degarelix  | **Covered Uses**: Prostate Cancer  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to Eligard and Zoladex.  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Oncologist, Urologist |
| Prolia    | denosumab  | **Covered Uses**: Osteoporosis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Documentation of all of the following:  
     i. Documentation of a T-score less than -2.5 at the spine or hip.  
     ii. Concurrently receiving calcium and vitamin D supplement.  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
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<td>iii. Documentation of “1” of the following:</td>
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<tr>
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<td>• Documented inadequate response to oral bisphosphonate within the past 6 months (180 days) (e.g. greater than 3 percent decrease in bone mineral density from baseline, or osteoporotic fracture while taking an oral bisphosphonate, etc.).</td>
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<tr>
<td></td>
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<td>• Patient is not a candidate for oral bisphosphonate (e.g. co-morbid GI condition, intolerance to an oral bisphosphonate, etc).</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Covered Uses: Treatment and prevention of surgical or drug-induced Osteoporosis</td>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Inadequate response or clinically significant adverse effects to a bisphosphonate.</td>
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<td>b. Documentation of “1” of the following:</td>
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<tr>
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<td>i. Patient is receiving androgen deprivation therapy for prostate cancer (e.g. GnRH analog).</td>
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<td>ii. Orchiectomy</td>
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<td></td>
<td>iii. Patient is receiving an aromatase inhibitor for breast cancer.</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: N/A</td>
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<tr>
<td></td>
<td>desvenlafaxine succinate ER, desvenlafaxine fumarate ER</td>
<td>Covered Uses: Major Depressive Disorder</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary duloxetine or venlafaxine</td>
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<td>b. Failure or clinically significant adverse effects to at least a 6-week treatment course of &quot;1&quot; additional formulary antidepressant alternative: citalopram, escitalopram, fluoxetine, sertraline OR mirtazapine</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Psychiatrist (new start)</td>
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<tr>
<td>Austedo</td>
<td>deutetribenazine</td>
<td>Covered Uses: Treatment of chorea associated with Huntington’s disease</td>
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<td>Exclusion Criteria: Check CCS eligibility</td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Documentation of functional disability</td>
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<td></td>
<td></td>
<td>b. Failure or clinically significant adverse effects to tetrabenazine</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Neurologist</td>
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<tr>
<td></td>
<td></td>
<td>Covered Uses: Tardive Dyskinesia</td>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
<td>Required Medical Information: Must meet all the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Documentation of functional impairment</td>
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<td>Generic</td>
<td>Criteria</td>
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</tbody>
</table>
| **Dexilant**          | dexlansoprazole| b. Documentation of “1” of the following:  
                          i. Switching from a first-generation neuroleptic to a second-generation neuroleptic  
                          ii. Discontinuation or dose modification of the offending medication  
                          **Age Restrictions:** Must be age 18 years or older  
                          **Prescriber Restrictions:** Neurologist, Psychiatrist |
| **Dextroamphetamine**| solution       | **Covered Uses:** Must meet “1” of the following:  
                          a. Barrett’s esophagus  
                          b. Erosive esophagitis  
                          c. Duodenal ulcer disease  
                          d. Gastric ulcer  
                          e. H. pylori infection  
                          f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome)  
                          g. NSAID associated gastric ulcer  
                          h. Symptomatic GERD  
                          **Exclusion Criteria:** N/A  
                          **Required Medical Information:** Must meet all of the following requirements:  
                          a. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, esomeprazole DR, omeprazole, pantoprazole AND rabeprazole  
                          b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.  
                          **Age Restrictions:** N/A  
                          **Prescriber Restrictions:** N/A |
| **Dextroamphetamine**| solution       | **Covered Uses:** ADHD  
                          **Exclusion Criteria:** N/A  
                          **Required Medical Information:** Must meet “1” of the following requirements:  
                          a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia);  
                          b. Failure or clinically significant adverse effects to one of the preferred sprinkling capsule: methylphenidate CD or methylphenidate LA;  
                          c. Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dexmethylphenidate ER, dextroamphet, dextroamp-ER, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
                          **Age Restrictions:** N/A  
                          **Prescriber Restrictions:** N/A |
| **Dextroamphetamine**| solution       | **Covered Uses:** Narcolepsy  
                          **Exclusion Criteria:** N/A  
                          **Required Medical Information:** Must meet “1” of the following requirements:  
                          a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia);  
                          b. Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dexmethylphenidate ER, dextroamphet, dextroamp-ER, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi |
<table>
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<th>Brand</th>
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<th>Criteria</th>
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</table>
| Nuedexta | dextromethorphan, quinidine | **Covered Uses:** Pseudobulbar affect  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Zipsor   | diclofenac             | **Covered Uses:** Treatment of acute pain associated with musculoskeletal condition (e.g. strains, sprains, osteoarthritis)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to all of the following:  
   i. Formulary diclofenac AND  
   ii. Two additional formulary NSAID alternatives: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam, sulindac OR Voltaren gel  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Zorvolex | diclofenac             | **Covered Uses:** Treatment of acute pain associated with musculoskeletal condition (e.g. strains, sprains, osteoarthritis)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to all of the following:  
   i. Formulary diclofenac AND  
   ii. Two additional formulary NSAID alternatives: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam, sulindac OR Voltaren gel  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Flector  | diclofenac 3% gel      | **Covered Uses:** Actinic keratosis (i.e. solar keratosis)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to ALL of the alternatives: fluorouracil cream AND imiquimod cream  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |

| Flector  | diclofenac patch      | **Covered Uses:** Treatment of acute pain associated with musculoskeletal condition (e.g. strains, sprains, osteoarthritis)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  

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<th>Criteria</th>
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</table>
| Cambia      | Cambia diclofenac potassium oral solution    | a. Failure or clinically significant adverse effects to all of the following:  
  i. Formulary diclofenac;  
  ii. One additional formulary oral NSAID alternatives: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam or sulindac;  
  iii. Voltaren gel  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A |
| Cambia      | diclofenac sodium topical solution 1.5%      | Covered Uses: Acute treatment of migraine  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:**  
  a. Failure or clinically significant adverse effects to:  
     i. Formulary diclofenac and one additional formulary NSAID: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam or sulindac AND  
     ii. One formulary triptan: rizatriptan OR sumatriptan  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A |
| Durezol     | difluprednate                                 | Covered Uses: Treatment of acute pain associated with musculoskeletal condition (e.g. strains, sprains, osteoarthritis)  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to all of the following:  
     i. Formulary diclofenac;  
     ii. One additional formulary oral NSAID alternatives: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam or sulindac;  
     iii. Voltaren gel  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A |
| Durezol     |                                             | Covered Uses: Anterior uveitis  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the following: dexamethasone 0.1%, fluorometholone, FML Forte 0.25%, Maxidex or prednisolone 1%  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** Ophthalmologist, Optometrist |
| Durezol     |                                             | Covered Uses: Ocular pain  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the following: dexamethasone 0.1%, fluorometholone, FML Forte 0.25%, Maxidex or prednisolone 1% |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
<th>Criteria</th>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
<td>Ophthalmologist, Optometrist</td>
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<td>Covered Uses: Migraine headache</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<td></td>
<td>a. Failure or clinically significant adverse effects to “1” of the following: rizatriptan or rizatriptan ODT</td>
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<td>b. Failure or clinically significant adverse effects to the alternative: sumatriptan</td>
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<td>c. Failure or clinically significant adverse effects to “1” of the alternatives: Cafergot OR Migergot</td>
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<td>d. Must use concurrently with ONE of the following: amitriptyline, atenolol, divalproex, metoprolol, propranolol, topiramate, valproate or venlafaxine</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: N/A</td>
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<tr>
<td>Tecfidera</td>
<td>dimethyl fumarate</td>
<td>Covered Uses: Relapsing form of multiple sclerosis</td>
<td>Neurologist</td>
<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to “1” glatiramer product (glatiramer or Glatopa) and “1” of the following: Aubagio, Avonex, Betaseron, Extavia, Rebif or Plegridy; as evidenced by at least one of the following:</td>
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<td></td>
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<td>i. Member continues to have clinical relapses (at least one relapse within the past 12 months);</td>
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<td>ii. Member continues to have CNS lesion progression as shown in MRI;</td>
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<td>iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).</td>
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<td>Age Restrictions: N/A</td>
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<td></td>
<td>Prescriber Restrictions: Neurologist</td>
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<tr>
<td>Unituxin</td>
<td>dinutuximab</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Pulmozyme</td>
<td>dornase alfa</td>
<td>Covered Uses: Cystic fibrosis</td>
<td>Pulmonologist</td>
<td>Exclusion Criteria: CCS eligible</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<td>a. Confirmed diagnosis</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Pulmonologist</td>
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<tr>
<td>Silenor</td>
<td>doxepin</td>
<td>Covered Uses: Insomnia</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<td>a. Failure or clinically significant adverse effects to the following: zolpidem</td>
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<td>b. Failure or clinically significant adverse effects to “1” of the following: eszopiclone or zaleplon</td>
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<td>Brand</td>
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|       |         | **Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A  

**Diclegis**  
doxyllamine, pyridoxine HCl  

**Covered Uses**: Pregnancy-induced nausea and vomiting  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to the following: pyridoxine (vitamin B6)  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: OB-GYN specialist

|       |         | **Age Restrictions**: N/A  
**Prescriber Restrictions**: OB-GYN specialist  

**Dronabinol**  

**Covered Uses**: Chemotherapy-induced nausea and vomiting  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Documented concurrent chemotherapy  
  b. Failure or clinically significant adverse effects to the alternative: ondansetron  
  c. Failure or clinically significant adverse effects to "2" of the alternatives: dexamethasone, metoclopramide, prochlorperazine OR promethazine  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Hematologist, Oncologist

|       |         | **Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A  

**Trulicity**  
dulaglutide  

**Covered Uses**: Diabetes Mellitus Type II  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to all of the following requirements:  
    i. Metformin  
    ii. "1" of the following: Basaglar, Humalog Mix, Humulin Mix, Humulin N NPH, Novolin Mix, Novolin N NPH, glimepiride, glipizide, glipizide/metformin, glyburide, glyburide/metformin, Steglatro, Segluromet, Invokana, Invokamet or pioglitazone  
    iii. Ozempic  
  b. Documented HbA1c greater than 7 percent after 3 months (90 consecutive days) with the tried alternatives.  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A
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<th>Brand</th>
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</table>
|       | **duloxetine DR 40 mg** | **Covered Uses:** Major depressive disorder  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary duloxetine  
b. Failure or clinically significant adverse effects to at least a 6-week treatment course of "1" additional formulary antidepressant alternatives citalopram, escitalopram, fluoxetine, paroxetine, sertraline, bupropion, OR mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
|       |         |          |
|       |         | **Covered Uses:** Generalized anxiety disorder  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to at least a 4-week treatment course of formulary duloxetine  
b. Failure or clinically significant adverse effects to "1" additional formulary alternative: buspirone, escitalopram, paroxetine or duloxetine DR  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
|       |         |          |
|       |         | **Covered Uses:** Diabetic peripheral neuropathy  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to formulary duloxetine AND gabapentin (≥ 1200mg/day)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
|       |         |          |
|       |         | **Covered Uses:** Chronic musculoskeletal pain  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to formulary duloxetine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
|       |         |          |
| **Kalbitor** | **ecallantide, Dx-88** | Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria  
| **Soliris** | **eculizumab** | **Covered Uses:** Paroxysmal nocturnal hemoglobinuria (PNH)  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documentation of meningococcal vaccination at least 2 weeks prior to therapy initiation  
b. Flow cytometry confirmation of "1" of the following:  
i. At least 10% PNH type III red cells  

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</table>
|       | ii. Glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs)  
|       | c. Documentation of "1" of the following:  
|       | i. History of at least one transfusion in the prior 24 months due to documented hemoglobin of less than 7 g per dL in patients without anemia symptoms or less than 9 g per dL with anemia symptoms  
|       | ii. History of major adverse vascular events from thromboembolism  
|       | d. Requested dosage and administration are consistent with the FDA recommendations  
|       | **Age Restrictions:** N/A  
|       | **Prescriber Restrictions:** Hematologist, Immunologist, Transplant specialist |
|       | i. History of at least one transfusion in the prior 24 months due to documented hemoglobin of less than 7 g per dL in patients without anemia symptoms or less than 9 g per dL with anemia symptoms  
|       | ii. History of major adverse vascular events from thromboembolism  
|       | d. Requested dosage and administration are consistent with the FDA recommendations  
|       | **Age Restrictions:** N/A  
|       | **Prescriber Restrictions:** Hematologist, Immunologist, Transplant specialist |
| Radicava | edaravone | **Covered Uses:** Atypical hemolytic uremic syndrome (aHUS)  
|       | **Exclusion Criteria:** CCS eligible  
|       | **Required Medical Information:** Must meet all of the following requirement:  
|       | a. Documentation of meningococcal vaccination at least 2 weeks prior to therapy initiation  
|       | b. Requested dosage and administration are consistent with the FDA recommendations  
|       | **Age Restrictions:** N/A  
|       | **Prescriber Restrictions:** Hematologist, Immunologist, Transplant specialist |
| Zepatier | elbasivir, grazoprevir | Please refer to the Hepatitis C Drug Class Criteria |
|       | **Covered Uses:** Amyotrophic Lateral Sclerosis (ALS)  
|       | **Exclusion Criteria:** N/A  
|       | **Required Medical Information:** Must meet all of the following requirements:  
|       | a. Documented disease duration of two years or less  
|       | b. Documentation of normal respiratory function (FVC percentage equal to or greater than 80 percent)  
|       | c. Documentation that member has functionality for most activities of daily living [scores of 2 points or better on each item of the ALS Functional Rating Scale-Revised (ALSFRS-R)]  
|       | d. Concurrent use with riluzole or clinically significant adverse effects to riluzole  
|       | **Age Restrictions:** N/A  
|       | **Prescriber Restrictions:** Neurologist |
|       | **Covered Uses:** Migraine headache  
|       | **Exclusion Criteria:** N/A  
|       | **Required Medical Information:** Must meet all of the following requirements:  
|       | a. Failure or clinically significant adverse effects to "1" of the following: rizatriptan or rizatriptan ODT  
|       | b. Failure or clinically significant adverse effects to the following: sumatriptan  
|       | **Age Restrictions:** Must be age of 18 years or older  
<p>|       | <strong>Prescriber Restrictions:</strong> N/A |</p>
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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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| Empliciti | elotuzumab | **Covered Uses:** Chronic immune thrombocytopenia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Must meet "1" of the following requirements:  
   i. Failure or clinically significant adverse effects to "1" of the following: dexamethasone, hydrocortisone, methylprednisolone, prednisone or prednisolone  
   ii. Failure or clinically significant adverse effects to "1" of the following: intravenous immune globulins (IVIG) or WinRho  
   iii. Documented relapse after splenectomy  
   iv. Documented contraindication to splenectomy  
b. Must meet "1" of the following requirements:  
   i. Documentation platelet count is less than 30 \(\times 10^9\)/L  
   ii. Must meet all of the following requirements:  
      1. Documentation platelet count is less than 50 \(\times 10^9\)/L  
      2. Documentation of "1" clinical condition increasing the risk for bleeding: active bleeding, hypertension, peptic ulcer disease, recent surgery, trauma or being on anticoagulation therapy  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Hematologist |
| Promacta | eltrombopag | **Covered Uses:** Aplastic anemia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "1" of the following: Atgam or cyclosporine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Hematologist |
| Viberzi | eluxadoline | **Covered Uses:** Irritable bowel syndrome with diarrhea  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement: |
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<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
| Jardiance | empagliflozin | a. Failure or clinically significant adverse effects to ALL the alternatives: loperamide and dicyclomine  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* Gastroenterologist |
| Glyxambi | empagliflozin, linagliptin | **Covered Uses:** Diabetes Mellitus type II  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
1. Failure or clinically significant adverse effects to "1" of the following: acarbose, glimepiride, glipizide, glipizide-metformin, glyburide, glyburide-metformin, alogliptin, alogliptin-metformin or pioglitazone  
2. Failure or clinically significant adverse effects to "1" of the following: metformin  
3. Must meet "1" of the following:  
   i. Documentation of established atherosclerotic cardiovascular disease, chronic kidney disease or heart failure  
   ii. Documentation of compelling need to minimize weight gain or promote weight loss  
   iii. Must meet all of the following requirements:  
      1. Failure or clinically significant adverse effects to "1" of the following: Invokana, Invokamet, Steglatro or Segluromet  
      2. Failure or clinically significant adverse effects to "1" of the following: alogliptin, alogliptin-metformin  
      3. Must have a HbA1c greater than 7 percent after 90 days of treatment with the tried alternatives  
*Age Restrictions:* N/A  
*Prescriber Restrictions:* N/A |
<p>| Idhifa | enasidenib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Braftovi | encorafenib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Xtandi | enzalutamide | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |</p>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses:</th>
<th>Criteria</th>
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<tbody>
<tr>
<td></td>
<td>epinastine 0.05%</td>
<td>Allergic conjunctivitis</td>
<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet &quot;1&quot; of the following requirements:</td>
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<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: azelastine, cromolyn, olopatadine, or Zaditor</td>
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<td>b. Prescribed by an Ophthalmologist or Optometrist</td>
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<td>Prescriber Restrictions: See Required Medical Information</td>
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<tr>
<td>Procrit</td>
<td>epoetin</td>
<td>Please refer to Erythropoiesis-Stimulating Agents (ESAs) Drug Class Prior Authorization Criteria</td>
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<td></td>
<td>epoprostenol</td>
<td>Pulmonary Arterial Hypertension</td>
<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet “1” of the following requirements:</td>
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<td>a. Documented WHO Functional Class IV</td>
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<td>b. Documented WHO Functional Class III and “1” of the following:</td>
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<td>i. Evidence of rapid disease progression</td>
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<td>ii. Markers for poor clinical prognosis</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Cardiologist, Pulmonologist</td>
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<tr>
<td>Halaven</td>
<td>eribulin</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Tarceva</td>
<td>erlotinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<td>Aptiom</td>
<td>eslicarbazepine</td>
<td>Seizure (i.e. partial-onset seizure)</td>
<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the alternatives: carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate or zonisamide.</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Neurologist (new start)</td>
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<td>Nexium Granules</td>
<td>esomeprazole</td>
<td>Must meet &quot;1&quot; of the following:</td>
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<td></td>
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<td>a. Barrett's esophagus</td>
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<td>b. Erosive esophagitis</td>
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<td>c. Duodenal ulcer disease</td>
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<td>d. Gastric ulcer</td>
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<td>e. H. pylori infection</td>
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<td>f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome)</td>
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<td>g. NSAID associated gastric ulcer</td>
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<td>h. Symptomatic GERD</td>
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| Vagifem       | estradiol     | Exclusion Criteria: N/A  
 Required Medical Information: Must meet all of the following requirements:  
 a. ONE of the following:  
   i. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, omeprazole, esomeprazole, pantoprazole AND rabeprazole  
   ii. Documented difficulty swallowing AND Failure or clinically significant adverse effects to ALL of the alternatives: omeprazole capsule AND lansoprazole capsule sprinkled on apple sauce or juice as directed per package insert  
   iii. Documented tube feeding  
 b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.  
 Age Restrictions: N/A  
 Prescriber Restrictions: N/A                                                                                                                                   |
| Delestrogen   | estradiol valerate injectable | Covered Uses: Vulvar and vaginal atrophy associated with menopause  
 Exclusion Criteria: N/A  
 Required Medical Information: Must meet the following requirement:  
 a. Failure or clinically significant adverse effects to "2" of the following: Estrace vaginal cream, estradiol transdermal patch, estradiol tablet, Jinteli tablet, Menest tablet, Premarin tablet, Premarin vaginal cream, Premphase tablet or Prempro tablet  
 Age Restrictions: N/A  
 Prescriber Restrictions: N/A                                                                                                                                   |
|               |               | Covered Uses: Vasomotor symptoms associated with menopause or Vulvar and vaginal atrophy associated with menopause  
 Exclusion Criteria: N/A  
 Required Medical Information: Must meet the following requirement:  
 a. Failure or clinically significant adverse effects to "2" of the following: Estrace vaginal cream, estradiol transdermal patch, estradiol tablet, Jinteli tablet, Menest tablet, Premarin tablet, Premarin vaginal cream, Premphase tablet or Prempro tablet  
 Age Restrictions: N/A  
 Prescriber Restrictions: N/A                                                                                                                                   |
|               |               | Covered Uses: Hypoestrogenism due to hypogonadism, castration or primary ovarian failure  
 Exclusion Criteria: N/A  
 Required Medical Information: Must meet the following requirement:  
 a. Confirmed diagnosis  
 Age Restrictions: N/A  
 Prescriber Restrictions: OB-GYN specialist                                                                                                                        |
|               |               | Covered Uses: Advanced androgen-dependent carcinoma of the prostate  
 Exclusion Criteria: N/A                                                                                                                                                                                                                                                     |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>enbrel</td>
<td>etanercept</td>
<td>Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Afinitor</td>
<td>everolimus</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Zortress</td>
<td>everolimus</td>
<td>Covered Uses: Prophylaxis of organ rejection in transplant (e.g. Graft-Versus-Host Disease or GVHD)</td>
</tr>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td>Age Restrictions: N/A</td>
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<td></td>
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<td>Prescriber Restrictions: Geneticist, Pulmonologist OR Transplant specialist</td>
</tr>
<tr>
<td>Afinitor Disperz</td>
<td>everolimus tablet for suspension</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Repatha</td>
<td>evolocumab injection</td>
<td>Please refer to Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor Drug Class Prior Authorization Criteria</td>
</tr>
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<tr>
<td>Bydureon, Bydureon Bcise</td>
<td>exenatide</td>
<td>Covered Uses: Diabetes Mellitus Type II</td>
</tr>
<tr>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Metformin</td>
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<tr>
<td></td>
<td></td>
<td>ii. Ozempic after at least 6 months of continued use</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<td>---------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Uloric  | febuxostat               | **Covered Uses:** Gout  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the following: allopurinol  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Abstral | fentanyl (sublingual)    | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
| Fentora | fentanyl buccal          | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
|         | fentanyl lozenge         | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
| Lazanda | fentanyl nasal spray     | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
|         | fentanyl patch           | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
|         | 12mcg/hr, 25mcg/hr, 50mcg/hr |                                                                                                                                             |
| Subsys  | fentanyl SL spray        | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                 |
| Injectafer | ferric carboxymaltose  | **Covered Uses:** Iron-deficiency anemia, hemodialysis-dependent patients  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Failure or clinically significant adverse effects to all of the following: ferric gluconate IV and Venofer  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|         |                          | **Covered Uses:** Iron-deficiency anemia, non-dialysis-dependent patient  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Must meet "1" of the following requirements:  
i. Failure or clinically significant adverse effects to the following: ferrous sulfate tablet  
ii. Documentation that disorder of the GI (e.g. inflammatory bowel disease) may be aggravated by oral iron  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
<table>
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<tr>
<th>Brand</th>
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<th>Criteria</th>
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</table>
|       |         | iii. Documentation of decreased absorption of oral iron due to gastric bypass surgery and/or subtotal gastric resection  
|       |         | iv. Documentation that oral iron cannot compensate the severe anemia  
|       |         | b. Failure or clinically significant adverse effects to the following: Venofer  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** N/A  
|       |         | **Covered Uses:** Chemotherapy-induced anemia  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet the following requirement:  
|       |         | a. Confirmed diagnosis  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** Hematologist, Oncologist  
| Auryxia | ferric citrate |  
|       |         | **Covered Uses:** Chronic Kidney Disease (CKD): stage 3 to 5  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet all of the following requirements:  
|       |         | a. Documented high phosphate levels (greater than 4.5mg/dL)  
|       |         | b. Failure or clinically significant adverse effects to "1" of the following: Renagel or Renvela  
|       |         | c. Must meet "1" of the following requirements:  
|       |         | i. Failure or clinically significant adverse effects to the following: calcium acetate  
|       |         | ii. Elevated corrected calcium level greater than 9.5 mg/dL  
|       |         | iii. Low iPTH level (below laboratory reference range) with normal or elevated serum calcium associated with  
|       |         | adynamic bone disease  
|       |         | iv. Documentation of vascular calcification  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** N/A  
|       |         | **Covered Uses:** Iron Deficiency Anemia in CKD (stage 1 to 4) patients not on dialysis  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet all of the following requirements:  
|       |         | a. Failure or clinically significant adverse effects to “2” of the following: ferrous gluconate, ferrous sulfate or ferrous  
|       |         | fumarate  
|       |         | b. Documentation of low iron store (serum ferritin less than or equal to 500 ng per mL and serum transferrin  
|       |         | saturation (TSAT) less than or equal to 30 percent) within the past 3 months  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** Nephrologist  
| Toviaz | fesoterodine |  
|       |         | **Covered Uses:** Overactive bladder (OAB)  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet all of the following requirements:  
|       |         | a. Failure or clinically significant adverse effects to "2" of the alternatives: oxybutynin, oxybutynin ER, tolterodine, OR  

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<table>
<thead>
<tr>
<th>Brand</th>
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<th>Criteria</th>
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<tbody>
<tr>
<td></td>
<td>toterodine ER</td>
<td>b. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: trospium OR trospium ER</td>
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<td></td>
<td>Age Restrictions: N/A</td>
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<td></td>
<td></td>
<td>Prescriber Restrictions: N/A</td>
</tr>
<tr>
<td>Dificid</td>
<td>fidaxomicin</td>
<td>Covered Uses: Clostridium difficile diarrhea (C. Diff)</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to oral vancomycin</td>
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<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Prescriber Restrictions: Gastroenterologist, Infectious Disease specialist</td>
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<tr>
<td>Neupogen</td>
<td>filgrastim</td>
<td>Covered Uses: Must meet &quot;1&quot; of the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. Myelosuppressive chemotherapy recipients with nonmyeloid malignancies</td>
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<td></td>
<td>b. Acute Myeloid Leukemia (AML) following induction or consolidation chemotherapy</td>
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<td>c. Bone marrow transplantation</td>
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<td>d. Hematopoietic acute radiation injury syndrome</td>
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<td>e. Peripheral blood progenitor cell collection and therapy</td>
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<td>f. Severe chronic neutropenia</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet the following requirement:</td>
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<tr>
<td></td>
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<td>a. Failure or clinically significant adverse effects to &quot;1&quot; of the following: Granix or Zarxio</td>
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<td>Age Restrictions: N/A</td>
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<td>Prescriber Restrictions: Hematologist, Oncologist or HIV/Infectious Disease specialist</td>
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<tr>
<td>Gilenya</td>
<td>fingolimod</td>
<td>Covered Uses: Relapsing form of multiple sclerosis</td>
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<td>Exclusion Criteria: N/A</td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to “1” glatiramer product (glatiramer or Glatopa) and “1” of the following: Aubagio, Avonex, Betaseron, Extavia, Rebif or Plegridy, as evidenced by at least “1” of the following:</td>
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<tr>
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<td>i. Member continues to have clinical relapses (at least one relapse within the past 12 months);</td>
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<td>ii. Member continues to have CNS lesion progression as shown in MRI;</td>
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<td>iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).</td>
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<td>b. No history or recent (within the last 6 months) of any of the following cardiac conditions. Must have plan for cardiac monitoring at initiation by provider per label:</td>
</tr>
<tr>
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<td>i. Heart attack (&quot;myocardial infarction&quot;), chest pain while resting (&quot;unstable angina&quot;), stroke, mini-stroke (&quot;transient ischemic attack (TIA)&quot;); decompensated heart failure requiring hospitalization or Class III/IV heart failure within the last 6 months;</td>
</tr>
<tr>
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<td>ii. History or presence of second-degree or third-degree heart block (&quot;Mobitz Type II atrioventricular (AV) block&quot;) or sick sinus syndrome, unless patient has a functioning pacemaker;</td>
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<tr>
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<td>iii. Baseline QTc interval greater than or equal to 500 ms;</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<td>----------------------</td>
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</tr>
</tbody>
</table>
| Addyi                | flibanserin      | iv. Concurrent use of Class Ia or Class III anti-arrhythmic drug.  
|                      |                  | **Age Restrictions:** N/A  
|                      |                  | **Prescriber Restrictions:** Neurologist  
| Advair Diskus 500/50 mcg | fluticasone, salmeterol | **Covered Uses:** Hypoactive sexual desire disorder  
|                      |                  | **Exclusion Criteria:** Not a covered benefit  
|                      |                  | **Required Medical Information:** N/A  
|                      |                  | **Prescriber Restrictions:** N/A  
|                      |                  | **Other Criteria:** N/A  
| Advair Diskus 100/50mcg, 250/50mcg | fluticasone, salmeterol | **Covered Uses:** Asthma  
|                      |                  | **Exclusion Criteria:** N/A  
|                      |                  | **Required Medical Information:** Must meet the following requirement:  
|                      |                  | a. Failure or clinically significant adverse effects to formulary Fluticasone propionate/Salmeterol inhaler or AirDuo  
|                      |                  | **Age Restrictions:** Must be age of 12 and older;  
|                      |                  | **Prescriber Restrictions:** N/A  
|                      |                  | **Covered Uses:** COPD  
|                      |                  | **Exclusion Criteria:** N/A  
|                      |                  | **Required Medical Information:** Must meet the following requirement:  
|                      |                  | a. Failure or clinically significant adverse effects to one formulary long acting bronchodilator: Incruse Ellipta, Stiolto Respimat, Tudorza or Serevent.  
|                      |                  | **Age Restrictions:** N/A  
|                      |                  | **Prescriber Restrictions:** N/A  
|                      |                  | **Covered Uses:** Asthma  
|                      |                  | **Exclusion Criteria:** N/A  
|                      |                  | **Required Medical Information:** Must meet “1” of the following requirements:  
|                      |                  | a. Must meet all “2” requirements:  
|                      |                  | i. Ages 12 and older;  
|                      |                  | ii. Failure or clinically significant adverse effects to formulary Fluticasone propionate/Salmeterol inhaler or AirDuo.  
|                      |                  | b. Must meet all “2” requirements:  
|                      |                  | i. Ages 4 to 11 years;  
|                      |                  | ii. Failure or clinically significant adverse effects to two formulary inhaled corticosteroids: Asmanex, Flovent, Pulmicort or Qvar  
|                      |                  | **Age Restrictions:** Must be age of 4 and older;  
|                      |                  | **Prescriber Restrictions:** N/A  
|                      |                  | **Covered Uses:** COPD  
|                      |                  | **Exclusion Criteria:** N/A  
|                      |                  | **Required Medical Information:** Must meet the following requirement:  
|                      |                  | a. Failure or clinically significant adverse effects to one formulary long acting bronchodilator: Incruse Ellipta, Stiolto Respimat, Tudorza or Serevent.
<table>
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</thead>
</table>
| Advair HFA | fluticasone, salmeterol | **Covered Uses:** Asthma  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to formulary fluticasone propionate/salmeterol inhaler  
**Age Restrictions:** Must be age of 12 and older  
**Prescriber Restrictions:** N/A |
| Breo Ellipta | fluticasone, vilanterol   | **Covered Uses:** Asthma  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to formulary fluticasone propionate/salmeterol inhaler  
**Age Restriction:** Must be age of 18 and older  
**Prescriber Restrictions:** N/A  
**Covered Uses:** COPD  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to one formulary long acting bronchodilator: Incruse Ellipta, Stiolto Respimat, Tudorza or Serevent  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| frovatriptan |                          | **Covered Uses:** Migraine headache  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "1" of the following: rizatriptan or rizatriptan ODT  
b. Failure or clinically significant adverse effects to the following: sumatriptan  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
| Faslodex | fulvestrant              | **Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria** |
| Horizant | gabapentin               | **Covered Uses:** Postherpetic neuralgia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "2" of the following: gabapentin at dose greater than or equal to 1200mg/day and Lyrica  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
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<tr>
<th>Brand</th>
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<th>Criteria</th>
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</thead>
</table>
|              | Gralise gabapentin ER | **Covered Uses:** Postherpetic neuralgia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: gabapentin at dose greater than or equal to 1200mg/day and Lyrica  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  |
|              | galantamine capsule | **Covered Uses:** Alzheimer dementia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: donepezil, donepezil ODT, rivastigmine capsule, galantamine tablet  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  |
|              | galantamine oral solution | **Covered Uses:** Alzheimer dementia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet “1” of the following requirements:  
a. Failure or clinically significant adverse effects to “2” of the following: donepezil, donepezil ODT, rivastigmine, galantamine  
b. Must meet ALL of the following requirements:  
i. Documented difficulty swallowing (i.e. dysphagia)  
ii. Failure or clinically significant adverse effects to formulary donepezil ODT  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  |
| Zirgan       | ganciclovir      | **Covered Uses:** Herpetic keratitis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Failure or clinically significant adverse effects to the following: trifluridine  
b. Prescribed by an Ophthalmologist or Optometrist  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** See Required Medical Information |
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<tbody>
<tr>
<td>Iressa</td>
<td>gefitinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Glatopa | glatiramer | Covered Uses: Relapsing form of multiple sclerosis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: Neurologist |
| Mavyret | glecaprevir, pibrentasvir | Please refer to the Hepatitis C Drug Class Criteria |
| Ravicti | glycerol phenylbutyrate | Covered Uses: Hyperammonemia for the chronic management of urea cycle disorder  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet all of the following requirements:  
a. Documentation of concurrent dietary protein restriction with or without amino acid supplementation (e.g. Cyclinex, EAA OR UCD I&II)  
b. Failure or clinically significant adverse effects to the following: sodium phenylbutyrate  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Cuvposa | glycopyrrolate oral solution | Covered Uses: Chronic severe drooling with neurological conditions (e.g. cerebral palsy)  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the alternative: scopolamine patch  
Age Restrictions: N/A  
Prescriber Restrictions: Neurologist (new start) |
|  | glycopyrrolate tablet | Covered Uses: Peptic ulcer  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "2" of the alternatives: cimetidine, famotidine OR ranitidine  
b. Failure or clinically significant adverse effects to "2" of the alternatives: lansoprazole, omeprazole, pantoprazole OR rabeprazole |
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<tbody>
<tr>
<td>Simponi, Simponi Aria</td>
<td>golimumab</td>
<td>Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Zoladex      | goserelin    | Covered Uses: Endometriosis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Inadequate response or clinically significant adverse effects to a continuous or extended-cycle oral contraceptive (e.g. Camrese 3 month dose pack, Quasense 3 month dose pack).  
Age Restrictions: Must be age of 18 years or older  
Prescriber Restrictions: OB-GYN specialist |
<p>| Tremfya      | guselkumab   | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria |
| Gel-one      | hyaluronate acid | Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria |
| Orthovisc    | hyaluronate acid | Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria |
| Synvisc-One or Synvisc | hyaluronate acid | Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria |
| Zohydro ER   | hydrocodone  | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria |</p>
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<tbody>
<tr>
<td>Hysingla ER</td>
<td>hydrocodone bitartrate</td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
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<tr>
<td>hydromorphone</td>
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<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Exalgo ER</td>
<td>hydromorphone ER</td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| hydroxyprogesterone caproate PF vial | Covered Uses: Prevention of spontaneous preterm delivery  
Exclusion Criteria: N/A  
Required Medical Information:  
a. Documented history of a singleton spontaneous preterm birth or preterm birth (prior to 37 weeks gestation)  
b. Documented pregnancy with a single fetus  
c. Documentation of treatment initiation as early as 16 weeks 0 days, and end before 37 weeks (through week 36, 6 days) gestation  
Age Restrictions: N/A  
Prescriber Restrictions: OB-GYN specialist |
| hyoscyamine tablet, tablet dispersible, tablet sublingual, tablet ER | Covered Uses: Gastrointestinal disorders: abdominal cramp, peptic ulcer, irritable bowel syndrome, diverticulitis, acute enterocolitis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Imbruvica | ibrutinib                                   | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Duexis    | ibuprofen, famotidine                       | Covered Uses: Treatment of osteoarthritis or rheumatoid arthritis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to all of the following:  
i. Formulary ibuprofen and famotidine concurrently  
ii. One additional formulary NSAID alternative: etodolac, indomethacin, meloxicam, nabumetone, naproxen, piroxicam, sulindac  
iii. One additional formulary PPI alternative: esomeprazole, lansoprazole, omeprazole, pantoprazole OR rabeprazole  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Firazyr</td>
<td>icatibant</td>
<td>Please refer to Hereditary Angioedema (HAE) Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Zydelig</td>
<td>idelalisib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Ventavis | iloprost | **Covered Uses:** Pulmonary Arterial Hypertension  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Member is not a candidate for parenteral prostanoid therapy  
b. Must meet “1” of the following:  
   i. Documented WHO Functional Class IV  
   ii. Documented WHO Functional Class III and “1” of the following:  
      • Evidence of rapid disease progression  
      • Markers for poor clinical prognosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Cardiologist, Pulmonologist |
| imatinib |  | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| imipenem, cilastatin |  | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| imipramine pamoate |  | **Covered Uses:** Depression  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the alternative: imipramine HCL  
b. Failure or clinically significant adverse effects to "1" of the alternatives: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, bupropion OR mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Xeomin | incobotulinum toxin A | Please refer to Botulinum Toxin Drug Class Prior Authorization Criteria |
| Renflexis | infliximab-abda | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria |
| Tresiba | insulin degludec | **Covered Uses:** Diabetes Mellitus Type I or II  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the following: Basaglar  
b. Must have a HbA1c greater than 7 percent after 90 days of treatment with the tried alternative  
**Age Restrictions:** N/A |
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<th>Brand</th>
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<th>Criteria</th>
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| Levemir Flextouch | insulin detemir pen            | **Prescriber Restrictions:** Endocrinologist  
**Covered Uses:** Diabetes Mellitus I or II  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to Basaglar.  
b. Failure or clinically significant adverse effects to Levemir vial.  
c. Must have an HbA1c greater than 7 percent after 3 months (90 consecutive days) of treatment with alternatives.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
**Covered Uses:** Gestational Diabetes  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet “1” of the following requirements:  
a. Failure or significant adverse effects to Levemir vial.  
b. Documented dexterity or vision issues.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  

Levemir | insulin detemir vial            |  
**Covered Uses:** Gestational Diabetes  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  

Toujeo SoloStar | insulin glargine               |  
**Covered Uses:** Diabetes Mellitus Type I or II  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the following: Basaglar  
b. Must have a HbA1c greater than 7 percent after 90 days of treatment with the tried alternative  
**Age Restrictions:** N/A
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<tr>
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| Avonex | interferon beta-1A | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: glatiramer or Glatopa; as evidenced by at least “1” of the following:  
i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
ii. Member continues to have CNS lesion progression as shown in MRI;  
iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Endocrinologist |
| Rebif  | interferon beta-1A | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: glatiramer or Glatopa; as evidenced by at least “1” of the following:  
i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
ii. Member continues to have CNS lesion progression as shown in MRI;  
iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Betaseron | interferon beta-1B | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: glatiramer or Glatopa; as evidenced by at least “1” of the following:  
i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
ii. Member continues to have CNS lesion progression as shown in MRI;  
iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Extavia | interferon beta-1B | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: glatiramer or Glatopa; as evidenced by at least “1” of the following:  
i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
ii. Member continues to have CNS lesion progression as shown in MRI;  
iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
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<td>of the following:</td>
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<td></td>
<td></td>
<td>i. Member continues to have clinical relapses (at least one relapse within the past 12 months);</td>
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<tr>
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<td>ii. Member continues to have CNS lesion progression as shown in MRI;</td>
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<td>iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> Neurologist</td>
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<tr>
<td>Yervoy</td>
<td>ipilimumab</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Onivyde</td>
<td>irinotecan liposome inj</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| INFeD  | iron dextran                | **Covered Uses:** Iron-deficiency anemia, hemodialysis-dependent patients  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
**Covered Uses:** Iron-deficiency anemia, non-dialysis-dependent patient  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
  a. Failure or clinically significant adverse effects to the following: ferrous sulfate tablet  
  b. Documentation that disorder of the GI (e.g. inflammatory bowel disease) may be aggravated by oral iron  
  c. Documentation of decreased absorption of oral iron due to gastric bypass surgery and/or subtotal gastric resection  
  d. Documentation that oral iron cannot compensate the severe anemia  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A  
**Covered Uses:** Chemotherapy-induced anemia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Hematologist, Oncologist  
**Covered Uses:** Iron-deficiency anemia, hemodialysis-dependent patients  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
**Venofer** | iron sucrose                |
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<tr>
<th>Brand</th>
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</table>
|         |         | a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|         |         | Covered Uses: Iron-deficiency anemia, non-dialysis-dependent patient  
Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
a. Failure or clinically significant adverse effects to the following: ferrous sulfate tablet  
b. Documentation that disorder of the GI (e.g. inflammatory bowel disease) may be aggravated by oral iron  
c. Documentation of decreased absorption of oral iron due to gastric bypass surgery and/or subtotal gastric resection  
d. Documentation that oral iron cannot compensate the severe anemia  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|         |         | Covered Uses: Chemotherapy-induced anemia  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: Hematologist, Oncologist |
|         |         | Covered Uses: Acne, severe recalcitrant nodulocystic  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "2" of the following: benzoyl peroxide topical, clindamycin topical, erythromycin topical or tretinoin topical  
b. Failure or clinically significant adverse effects to "1" of the following: doxycycline, minocycline or tetracycline  
Age Restrictions: N/A  
Prescriber Restrictions: Dermatologist |
|         |         | Covered Uses: Must meet "1" of the following:  
a. Aspergillusosis  
b. Blastomycosis  
c. Coccidioidomycosis  
d. Cryptococcosis  
e. Histoplasmosis  
f. Prophylaxis for fungal infection in HIV patients  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement: |
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<tr>
<th>Brand</th>
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|       |         | a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|       |         | Covered Uses: Onychomycosis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the formulary alternative: terbinafine  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|       |         | Covered Uses: Must meet “1” of the following:  
a. Oropharyngeal candidiasis  
b. Candidiasis of the esophagus  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to ALL of the formulary alternatives: nystatin AND fluconazole  
Age Restrictions: N/A  
Prescriber Restrictions: HIV specialist, Infectious Disease specialist |
| Corlanor | ivabradine | Covered Uses: Heart Failure  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Documented ejection fraction less than 35 percent  
b. Documented concurrent use with "1" of the following: carvedilol or metoprolol succinate ER  
Age Restrictions: N/A  
Prescriber Restrictions: Cardiologist |
| Kalydeco | ivacaftor | Covered Uses: Cystic fibrosis  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet the following requirement:  
a. Documentation of "1" mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data  
Age Restrictions: Must be age of 1 year or older  
Prescriber Restrictions: Pulmonologist |
| Orkambi | ivacaftor, lumacaftor | Covered Uses: Cystic fibrosis  
Exclusion Criteria: CCS eligible  
Required Medical Information: Must meet the following requirement:  
a. Documentation confirming that the member is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene  
Age Restrictions: Must be age of 2 years and older |
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<tr>
<th>Brand</th>
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<th>Criteria</th>
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<tbody>
<tr>
<td>Symdeko</td>
<td>ivacaftor/tezacaftor</td>
<td><strong>Prescriber Restrictions:</strong> Pulmonologist</td>
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<td></td>
<td></td>
<td><strong>Covered Uses:</strong> Cystic fibrosis</td>
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<tr>
<td></td>
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<td><strong>Exclusion Criteria:</strong> CCS eligible</td>
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<td><strong>Required Medical Information:</strong> Must meet one of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Documentation confirming that the member is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regular (CFTR) gene</td>
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<td>b. Documentation of at least &quot;1&quot; mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on clinical and/or in vitro assay data</td>
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<td><strong>Age Restrictions:</strong> Must be age of 12 years or older</td>
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<td><strong>Prescriber Restrictions:</strong> Pulmonologist</td>
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<tr>
<td>Soolantra</td>
<td>ivermectin cream</td>
<td><strong>Covered Uses:</strong> Rosacea</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
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<td>a. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: metronidazole cream, metronidazole gel OR metronidazole lotion</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Sklice</td>
<td>ivermectin lotion</td>
<td><strong>Covered Uses:</strong> Pediculosis capitis (Head lice)</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or significant adverse effects to &quot;1&quot; OTC fromulary alternatives: permethrin 1% topical liquid or RID (pyrethrin plus piperonyl butoxide)</td>
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<td>b. Failure or significant adverse effects to &quot;1&quot; prescription fromulary alternatives: spinosad 0.9% topical suspension or malathion 0.5% lotion</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td>ivermectin tablet</td>
<td><strong>Covered Uses:</strong> Must meet “1” of the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. Onchocerciasis or infection caused by Onchocerca volvulus (river blindness)</td>
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<td>b. Strongyloidiasis or infection caused by Strongyloides specicies (roundworm)</td>
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<td></td>
<td></td>
<td>c. Ascariasis or infection caused by Ascaris lumbricoides (roundworm)</td>
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<td>d. Scabies caused by Sarcoptes scabiei (itch mite)</td>
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<td>e. Infestation by Phthirus pubis (pubic or crab louse)</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td>Brand</td>
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<tr>
<td>Immuno-Globulin</td>
<td>IVIG</td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> N/A&lt;br&gt;&lt;br&gt;<strong>Please refer to Immunoglobulin (IVIG) Drug Class Prior Authorization Criteria</strong></td>
</tr>
<tr>
<td>Ninlaro</td>
<td>ixazomib</td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
</tr>
<tr>
<td>Taltz</td>
<td>ixekizumab</td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</strong></td>
</tr>
<tr>
<td>Vimpat</td>
<td>lacosamide</td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Covered Uses:</strong> Seizure (i.e. partial onset seizure)&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet the following requirement:&lt;br&gt;  a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate or zonisamide.&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Neurologist (new start)</td>
</tr>
<tr>
<td>Lamotrigine ER</td>
<td></td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Covered Uses:</strong> Seizure&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet the following requirement:&lt;br&gt; a. Failure or clinically significant adverse effects to the alternative: lamotrigine&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Neurologist</td>
</tr>
<tr>
<td>Somatuline Depot</td>
<td>lanreotide</td>
<td><strong>Criteria</strong>&lt;br&gt;<strong>Covered Uses:</strong> Acromegaly&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet the following requirement:&lt;br&gt;  a. Failure or clinically significant adverse effects to Sandostatin LAR depot and Signifor LAR&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Endocrinologist&lt;br&gt;&lt;br&gt;<strong>Covered Uses:</strong> Carcinoid&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet the following requirement:&lt;br&gt;  a. Failure or clinically significant adverse effects to Sandostatin LAR depot&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Endocrinologist&lt;br&gt;&lt;br&gt;<strong>Covered Uses:</strong> Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)</td>
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| Lanthanum Carbonate   |         | Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
a. Documented high phosphate levels (greater than 4.5mg/dL)  
b. Failure or clinically significant adverse effects to "1" of the following: Renagel or Renvela  
c. Must meet "1" of the following requirements:  
i. Failure or clinically significant adverse effects to the following: calcium acetate  
ii. Elevated corrected calcium level greater than 9.5 mg/dL  
iii. Low iPTH level (below laboratory reference range) with normal or elevated serum calcium associated with adynamic bone disease  
iv. Documentation of vascular calcification  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Lansoprazole Disintegrating DR |         | Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
a. Confirmed diagnosis  
b. NCCN guideline approved regimen  
Age Restrictions: N/A  
Prescriber Restrictions: Oncologist |
| Lansoprazole Disintegrating DR |         | Covered Uses: Must meet "1" of the following:  
a. Barrett’s esophagus  
b. Erosive esophagitis  
c. Duodenal ulcer disease  
d. Gastric ulcer  
e. H. pylori infection  
f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome)  
g. NSAID associated gastric ulcer  
h. Symptomatic GERD  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. ONE of the following:  
   i. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, omeprazole, esomeprazole DR, pantoprazole AND rabeprazole  
   ii. Documented difficulty swallowing AND Failure or clinically significant adverse effects to ALL of the alternatives: omeprazole capsule AND lansoprazole capsule sprinkled on apple sauce or juice as directed per package insert  
   iii. Documented tube feeding  
b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Lansoprazole Disintegrating DR |         | Covered Uses: Chronic Kidney Disease (CKD): stage 3 to 5  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Documented high phosphate levels (greater than 4.5mg/dL)  
b. Failure or clinically significant adverse effects to "1" of the following: Renagel or Renvela  
c. Must meet "1" of the following requirements:  
i. Failure or clinically significant adverse effects to the following: calcium acetate  
ii. Elevated corrected calcium level greater than 9.5 mg/dL  
iii. Low iPTH level (below laboratory reference range) with normal or elevated serum calcium associated with adynamic bone disease  
iv. Documentation of vascular calcification  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
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<tbody>
<tr>
<td>Tykerb</td>
<td>lapatinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<td></td>
<td>ledipasvir, sofosbuvir</td>
<td>Please refer to the Hepatitis C Drug Class Criteria</td>
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<tr>
<td>Revlimid</td>
<td>lenalidomide</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Lenvima</td>
<td>lenvatinib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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</tbody>
</table>
| Zurampic            | lesinurad                | Covered Uses: Gout  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
   a. Documented uric acid level of 6.5mg/dL or greater  
   b. Inadequate response or clinically significant adverse effects to all of the following: allopurinol and Uloric  
   c. Documentation of concurrent therapy with "1" of the following: allopurinol or Uloric  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Kisqali Femara Co-Pack | letrozole, ribociclib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Eligard             | leuprolide               | Covered Uses: Prostate Cancer  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
   a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: Oncologist, Urologist |
| Lupron / Lupron Depot | leuprolide              | Covered Uses: Endometriosis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
   a. Inadequate response or clinically significant adverse effects to a continuous or extended-cycle oral contraceptive (e.g. Camrese 3 month dose pack, Quasense 3 month dose pack).  
   b. Inadequate response or clinically significant adverse effects to Zoladex.  
Age Restrictions: Must be age of 18 years or older  
Prescriber Restrictions: OB-GYN specialist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lupron Depot Ped</td>
<td>leuprolide</td>
<td>Covered Uses: Prostate Cancer</td>
<td>N/A</td>
<td>Must meet the following requirement:</td>
<td>N/A</td>
<td>Oncologist, Urologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>a. Confirmed diagnosis of FDA labeled indication or NCCN recommended regimen of category 2B or above</td>
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<tr>
<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Covered Uses: Breast Cancer</td>
<td>N/A</td>
<td>Must meet the following requirement:</td>
<td>N/A</td>
<td>Oncologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>a. Confirmed diagnosis of FDA labeled indication or NCCN recommended regimen of category 2B or above</td>
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<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Covered Uses: Uterine Leiomyomata (i.e. fibroids)</td>
<td>N/A</td>
<td>Must meet the following requirement:</td>
<td>Must be age of 18 years or older</td>
<td>OB-GYN specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<tr>
<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Covered Uses: Central Precocious Puberty</td>
<td>N/A</td>
<td>Must meet the following requirement:</td>
<td>N/A</td>
<td>Pediatrician, Endocrinologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>a. Onset of secondary sexual characteristics in “1” of the following:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>i. Females less than 8 years of age</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Covered Uses: Bronchospasm: asthma</td>
<td>N/A</td>
<td>Must meet the following requirement:</td>
<td>N/A</td>
<td>Pulmonologist or Allergist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>a. Failure or clinically significant adverse effects to the following: albuterol sulfate HFA or Ventolin</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spritam</td>
<td>levetiracetam</td>
<td>Covered Uses: Must meet &quot;1&quot; of the following:</td>
<td></td>
<td>a. Partial onset seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td></td>
<td>b. Myoclonic seizures</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Required Medical Information:</td>
<td></td>
<td>c. Primary generalized tonic-clonic seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Exclusion Criteria: N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to the alternative: levetiracetam</td>
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<td>b. Documented concurrent treatment with at least one other anticonvulsant drug</td>
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<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Neurologist</td>
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<table>
<thead>
<tr>
<th>Fetzima</th>
<th>levomilnacipran</th>
<th>Covered Uses: Major Depressive Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary duloxetine or venlafaxine</td>
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<td></td>
<td>b. Failure or clinically significant adverse effects to at least a 6-week treatment course of &quot;1&quot; additional formulary antidepressant alternative: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER OR mirtazapine</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Psychiatrist (new start)</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Endari</th>
<th>l-glutamine</th>
<th>Covered Uses: Sickle-cell disease</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Documentation of concurrent use of hydroxyurea</td>
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<tr>
<td></td>
<td></td>
<td>b. Documentation of two or more painful crisis within the past 12 months</td>
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<tr>
<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Hematologist</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Linzess</th>
<th>linaclotide</th>
<th>Covered Uses: Must meet &quot;1&quot; of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a. Irritable Bowel Syndrome-related constipation (IBS-C)</td>
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<tr>
<td></td>
<td></td>
<td>b. Idiopathic chronic constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;1&quot; drug from any &quot;2&quot; of the groups:</td>
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<tr>
<td></td>
<td></td>
<td>i. fiber or psyllium</td>
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<tr>
<td></td>
<td></td>
<td>ii. polyethylene glycol powder or lactulose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. bisacodyl or senna</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tradjenta</th>
<th>linagliptin</th>
<th>Covered Uses: Diabetes Mellitus Type II</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to all of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Metformin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. &quot;1&quot; of the formulary DPP-4 inhibitor products: alogliptin, alogliptin-metformin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. &quot;1&quot; additional oral formulary alternatives: acarbose, glimepiride, glipizide, glipizide/metformin, glyburide,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>glyburide/metformin, Invokana, Invokamet, Steglatro, Segluromet or pioglitazone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Documented HbA1c greater than 7 percent after 90 consecutive days of optimal therapy with the tried alternatives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
</tbody>
</table>

| linezolid (IV) |         | **Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria**                                               |

| linezolid (oral) |         | **Covered Uses:** MRSA (Methicillin-Resistant Staphylococcus aureus) infection                                                        |
|                 |         | **Exclusion Criteria:** N/A                                                                                                           |
|                 |         | **Required Medical Information:** Must meet the following requirement:                                                               |
|                 |         | a. Failure or clinically significant adverse effects to "1" of the alternatives: clindamycin, doxycycline, minocycline OR sulfamethoxazole-trimethoprim |
|                 |         | **Age Restrictions:** N/A                                                                                                             |
|                 |         | **Prescriber Restrictions:** N/A                                                                                                      |

| linezolid (oral) |         | **Covered Uses:** Must meet “1” of the following:                                                                                   |
|                 |         | a. VRSA (Vancomycin-Resistant Staphylococcus aureus) infection                                                                      |
|                 |         | b. VRE (Vancomycin-Resistant Enterococcus) infection                                                                               |
|                 |         | **Exclusion Criteria:** N/A                                                                                                           |
|                 |         | **Required Medical Information:** Must meet the following requirement:                                                               |
|                 |         | a. Confirmed diagnosis                                                                                                              |
|                 |         | **Age Restrictions:** N/A                                                                                                             |
|                 |         | **Prescriber Restrictions:** N/A                                                                                                      |

<p>| Victoza | liraglutide | <strong>Covered Uses:</strong> Diabetes Mellitus type II  |
|         |             | <strong>Exclusion Criteria:</strong> N/A                                                                                                           |
|         |             | <strong>Required Medical Information:</strong> Must meet the following requirements:                                                             |
|         |             | a. Failure or clinically significant adverse effects to the following: metformin                                                    |
|         |             | b. Must meet &quot;1&quot; of the following requirements:                                                                                     |
|         |             | i. Documentation of established atherosclerotic cardiovascular disease                                                              |
|         |             | ii. Must meet all of the following requirements:                                                                                     |
|         |             | 1. Failure or clinically significant adverse effects to &quot;1&quot; of the following: Basaglar, Humalog Mix, Humulin Mix, Humulin N NPH, Novolin Mix, Novolin N NPH, glimepiride, glipizide, glipizide/metformin, glyburide, glyburide/metformin, Invokana, Invokamet, Steglatro, Segluromet or pioglitazone |
|         |             | 2. Failure or clinically significant adverse effects to Ozempic                                                                      |
|         |             | 3. Must have a HbA1c greater than 7 percent after 3 months (90 consecutive days) with the tried alternatives                         |
|         |             | <strong>Age Restrictions:</strong> N/A                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
</tr>
</thead>
</table>
| Saxenda | liraglutide recombinant | Obesity | N/A | Must meet all of the following requirements:  
- Failure or clinically significant adverse effects to all of the following:  
  - Alli  
  - Phentermine  
- Must meet "1" of the following requirements:  
  - BMI greater than or equal to 30 kilograms per meter squared.  
  - BMI greater than or equal to 27 kilograms per meter squared with comorbidity. A comorbidity is defined as but not limited to one of the following:  
    - Diabetes Mellitus Type II  
    - Coronary Heart Disease  
    - Hyperlipidemia  
    - Hypertension  
    - Sleep Apnea | N/A | N/A |
| Vyvanse | lisdexamfetamine | ADHD | N/A | Must meet "1" of the following requirements:  
- History of substance abuse;  
- Failure or clinically significant adverse effects to "2" of the following: dextroamp-amphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexamethylphenidate ER | N/A | N/A |
| Alrex | loteprednol 0.2% | Allergic conjunctivitis | N/A | Must meet "1" of the following:  
- Failure or clinically significant adverse effects to "2" of the following: cromolyn, olopatadine, or Zaditor  
- Prescribed by an Ophthalmologist or Optometrist | N/A | N/A |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lotemax</td>
<td>loprednol 0.5%</td>
<td><strong>Covered Uses</strong>: Pain, inflammation associated with ocular surgery&lt;br&gt;<strong>Exclusion Criteria</strong>: N/A&lt;br&gt;<strong>Required Medical Information</strong>: Must meet the following requirement: &lt;br&gt;a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: dexamethasone 0.1%, diclofenac 0.1%, fluorometholone, FML Forte 0.25%, ketorolac 0.4%, ketorolac 0.5%, Maxidex or prednisolone 1%&lt;br&gt;<strong>Age Restrictions</strong>: N/A&lt;br&gt;<strong>Prescriber Restrictions</strong>: Ophthalmologist, Optometrist</td>
</tr>
<tr>
<td>Lotemax</td>
<td>loprednol 0.5%</td>
<td><strong>Covered Uses</strong>: Pain, inflammation associated with ocular surgery&lt;br&gt;<strong>Exclusion Criteria</strong>: N/A&lt;br&gt;<strong>Required Medical Information</strong>: Must meet the following requirement: &lt;br&gt;a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: dexamethasone 0.1%, diclofenac 0.1%, fluorometholone, FML Forte 0.25%, ketorolac 0.4%, ketorolac 0.5%, Maxidex or prednisolone 1%&lt;br&gt;<strong>Age Restrictions</strong>: N/A&lt;br&gt;<strong>Prescriber Restrictions</strong>: Ophthalmologist, Optometrist</td>
</tr>
<tr>
<td>Amitiza</td>
<td>lubiprostone</td>
<td><strong>Covered Uses</strong>: Irritable Bowel Syndrome-related constipation (IBS-C)&lt;br&gt;<strong>Exclusion Criteria</strong>: N/A&lt;br&gt;<strong>Required Medical Information</strong>: Must meet all of the following requirements: &lt;br&gt;a. Failure or clinically significant adverse effects to &quot;1&quot; drug from any &quot;2&quot; of the groups: &lt;br&gt;i. fiber or psyllium &lt;br&gt;ii. polyethylene glycol powder or lactulose &lt;br&gt;iii. bisacodyl or senna &lt;br&gt;b. Females only&lt;br&gt;<strong>Age Restrictions</strong>: N/A&lt;br&gt;<strong>Prescriber Restrictions</strong>: N/A&lt;br&gt;Covered Uses: Must meet &quot;1&quot; of the following: &lt;br&gt;a. Idiopathic chronic constipation</td>
</tr>
<tr>
<td>Brand</td>
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<tr>
<td>Opsumit</td>
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<tr>
<td>maprotiline</td>
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<td>Emverm</td>
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<table>
<thead>
<tr>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| macitentan | b. Opioid-induced constipation  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "1" drug from any "2" of the groups:  
   i. fiber or psyllium  
   ii. polyethylene glycol powder or lactulose  
   iii. bisacodyl or senna  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| mebendazole chewtab | **Covered Uses:** Pulmonary Arterial Hypertension  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documented WHO Functional Class II or above.  
b. Failure or clinically significant adverse effect to sildenafil  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Cardiologist, Pulmonologist |
| | **Covered Uses:** Depression with anxiety  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "2" of the alternatives: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER OR mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Psychiatrist |
| | **Covered Uses:** Must meet "1" of the following:  
a. Ascariasis or infection caused by Ascaris lumbricoides (roundworm)  
b. Ancylostomiasis or infection caused by Ancylostoma duodenale (hookworm)  
c. Necatoriasis or infection caused by Necator americanus (hookworm)  
b. Trichuriasis or infection caused by Trichuris trichiura (whipworm)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| | **Covered Uses:** Enterobiasis or infection caused by Enterobius vermicularis (pinworm)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the following alternative: pyrantel pamoate |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valchlor</td>
<td>mechlorethamine gel</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>mefloquine</td>
<td></td>
<td><strong>Covered Uses</strong>: Prevention of malaria</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information</strong>: Must meet &quot;1&quot; of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: chloroquine, doxycycline, hydroxychloroquine OR primaquine</td>
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<td></td>
<td>b. CDC guideline</td>
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<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
</tr>
<tr>
<td>melphalan</td>
<td></td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>memantine ER</td>
<td></td>
<td><strong>Covered Uses</strong>: Alzheimer dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td></td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to formulary memantine</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
</tr>
<tr>
<td>Namzaric</td>
<td>memantine ER, donepezil</td>
<td><strong>Covered Uses</strong>: Alzheimer dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Medical justification why formulary donepezil and Namenda ER cannot be used concurrently</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
</tr>
<tr>
<td>meperidine</td>
<td></td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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</tr>
<tr>
<td>Nucala</td>
<td>mepolizumab</td>
<td>Please refer to Nucala Drug Prior Authorization Criteria</td>
</tr>
<tr>
<td></td>
<td>meropenem</td>
<td>Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Delzicol  | mesalamine | **Covered Uses:** Ulcerative Colitis (UC)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "1" of the following: balsalazide OR sulfasalazine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Gastroenterologist |
| mesalamine DR 1.2g tablet | **Covered Uses:** Crohn's disease  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Gastroenterologist |
|           | mesalamine enema | **Covered Uses:** Must meet "1" of the following:  
  a. Ulcerative colitis  
  b. Ulcerative proctitis  
  c. Ulcerative proctosigmoiditis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Confirmed diagnosis |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
|        | mesalamine suppository          | **Covered Uses**: Ulcerative proctitis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Gastroenterologist |
|        | metaxalone                      | **Covered Uses**: Treatment of acute, painful musculoskeletal condition (e.g. neck pain, low back pain)  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "2" of the following: cyclobenzaprine, methocarbamol or tizanidine  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| Synjardy | metformin, empagliflozin       | **Covered Uses**: Diabetes Mellitus type II  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the requirements:  
a. Failure or clinically significant adverse effects to the following: metformin  
b. Must meet "1" of the following requirements:  
i. Documentation of established atherosclerotic cardiovascular disease  
ii. Must meet all of the following requirements:  
1. Failure or clinically significant adverse effects to "1" of the following: Invokana, Invokamet, Steglatro or Segluromet  
2. Failure or clinically significant adverse effects to "1" of the following: acarbose, glimepiride, glipizide, glipizide-metformin, glyburide, glyburide-metformin, alogliptin, alogliptin-metformin OR pioglitazone  
3. Must have a HbA1c greater than 7 percent after 90 days of treatment with the tried alternatives  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
|        | methadone                       | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria                                                                                                                                 |
|        | methamphetamine                | **Covered Uses**: ADHD  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically adverse effects to at least "1" long acting formulary stimulant (e.g. dextroamp-amphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER) and "2" additional formulary stimulants  
**Age Restrictions**: Must be children age of 6 years and older but younger than 18 years old  
**Prescriber Restrictions**: Psychiatrist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Otrexup</strong></td>
<td>methotrexate</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Uses</strong>: Obesity</td>
<td></td>
<td></td>
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<tr>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<tr>
<td><strong>Required Medical Information</strong>: Must meet all of the following:</td>
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<tr>
<td>a. Must meet BMI Required Medical Information (please see the anti-obesity drug class prior authorization protocol);</td>
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<tr>
<td>b. Failure or clinically adverse effects to orlistat, phentermine and diethylpropion</td>
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<tr>
<td><strong>Age Restrictions</strong>: N/A</td>
<td></td>
<td></td>
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<tr>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
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</tr>
</tbody>
</table>

| **Covered Uses**: Juvenile idiopathic arthritis |
| **Exclusion Criteria**: N/A                   |
| **Required Medical Information**: Must meet all of the following requirements: |
| a. Failure or clinically significant adverse effects to ONE of the alternatives: celecoxib, diclofenac, etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen, piroxicam OR sulindac |
| b. Failure or clinically significant adverse effects to ALL of the alternatives: methotrexate tablet AND generic methotrexate injection solution |
| **Age Restrictions**: Must be age of 2 years or older |
| **Prescriber Restrictions**: Dermatologist, Rheumatologist |

| **Covered Uses**: Psoriasis                     |
| **Exclusion Criteria**: N/A                   |
| **Required Medical Information**: Must meet all of the following requirements: |
| a. Failure or clinically significant adverse effects to ONE of the alternatives: cyclosporine OR phototherapy |
| b. Failure or clinically significant adverse effects to ALL of the alternatives: methotrexate tablet AND generic methotrexate injection solution |
| **Age Restrictions**: N/A                     |
| **Prescriber Restrictions**: Dermatologist, Rheumatologist |

<p>| <strong>Covered Uses</strong>: Rheumatoid arthritis         |
| <strong>Exclusion Criteria</strong>: N/A                   |
| <strong>Required Medical Information</strong>: Must meet all of the following requirements: |
| a. Failure or clinically significant adverse effects to ONE of the alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide OR sulfasalazine |
| b. Failure or clinically significant adverse effects to ALL of the alternatives: methotrexate tablet AND generic methotrexate injection solution |
| <strong>Prescriber Restrictions</strong>: Dermatologist, Rheumatologist |</p>
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xatmep</td>
<td>methotrexate oral solution</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Mircera</td>
<td>methoxy peg-epoetin beta</td>
<td>Please refer to Erythropoiesis-Stimulating Agents (ESAs) Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Relistor (injectable) | methylnaltraxone | Covered Uses: Opioid-induced constipation (non-cancer)  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to all of the alternatives: Amitiza and Movantik  
b. Failure or clinically significant adverse effects to "1" of the alternatives: fiber, polyethylene glycol powder or psyllium  
c. Failure or clinically significant adverse effects to "1" of the alternatives: bisacodyl, lactulose or senna  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| Relistor (oral) | methylnaltraxone | Covered Uses: Opioid-induced constipation (advanced illness or cancer)  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Documentation of advanced illness receiving palliative or hospice care  
b. Must meet "1" of the following:  
i. Documentation of difficulty swallowing  
ii. Failure or clinically significant adverse effects to "1" drug from any "2" of the groups:  
1. docusate at dosage greater than or equal to 200mg/day  
2. polyethylene glycol powder or lactulose  
3. bisacodyl or senna  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| methylphenidate 5mg/5ml, 10mg/5ml solution |  | Covered Uses: ADHD  
Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia);  
b. Failure or clinically significant adverse effects to one of the preferred sprinkling capsule: methylphenidate CD or |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Quillivant XR                 | methylphenidate 5mg/ml ER solution       | Covered Uses: ADHD  
Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
   a. Documented difficulty swallowing (i.e. dysphagia):  
      i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA  
   b. Failure or clinically significant adverse effects to "2" of the following: dextroamp-amphetamine ER, dextroamphetamine ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|                               | methylphenidate chewable                 | Covered Uses: ADHD  
Exclusion Criteria: N/A  
Required Medical Information: Must meet "1" of the following requirements:  
   a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia);  
   b. Failure or clinically significant adverse effects to one of the preferred sprinkling capsule: methylphenidate CD or methylphenidate LA ; OR  
   c. Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dexmethylphenidate ER, dextroamp-amphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|                               | methylphenidate LA;                      | c. Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dexmethylphenidate ER, dextroamp-amphetamine ER, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
|                               | Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dexmethylphenidate ER, dextroamp-amphetamine, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |

Covered Uses: Narcolepsy
Exclusion Criteria: N/A
Required Medical Information: Must meet "1" of the following requirements:
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Quillichew ER</td>
<td>methylphenidate</td>
<td>a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia);</td>
</tr>
<tr>
<td></td>
<td>chewable tablet</td>
<td>b. Failure or clinically significant adverse effects to two formulary stimulants: dexmethylphenidate, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zenzedi</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td>methylphenidate</td>
<td><strong>Covered Uses:</strong> ADHD</td>
</tr>
<tr>
<td></td>
<td>ER</td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet &quot;1&quot; of the following requirements:</td>
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<td></td>
<td></td>
<td>a. Documented difficulty swallowing (i.e. dysphagia):</td>
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<td></td>
<td></td>
<td>i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA</td>
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<td>b. Failure or clinically significant adverse effects to &quot;2&quot; of the following: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER</td>
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<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Aptensio XR</td>
<td>methylphenidate</td>
<td><strong>Covered Uses:</strong> ADHD</td>
</tr>
<tr>
<td></td>
<td>ER</td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to at least two formulary long-acting stimulants: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Cotempla XR-ODT</td>
<td>methylphenidate</td>
<td><strong>Covered Uses:</strong> ADHD</td>
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<td></td>
<td>ER-ODT</td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet &quot;1&quot; of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Administration via feeding tube or documented difficulty swallowing (i.e. dysphagia)</td>
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<tr>
<td></td>
<td></td>
<td>i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA</td>
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<tr>
<td></td>
<td></td>
<td>b. Failure or clinically significant adverse effects to at least two formulary long-acting stimulants: dextroamphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexmethylphenidate ER</td>
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<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Daytrana</td>
<td>methylphenidate</td>
<td><strong>Covered Uses:</strong> ADHD</td>
</tr>
<tr>
<td></td>
<td>transdermal</td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet &quot;1&quot; of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>a. Documented difficulty swallowing (i.e. dysphagia):</td>
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<tr>
<td></td>
<td></td>
<td>i. Failure or clinically significant adverse effects to one of the preferred sprinkling capsules: methylphenidate CD or methylphenidate LA</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<td></td>
<td>methylphenidate LA</td>
<td>b. Failure or clinically significant adverse effects to &quot;2&quot; of the following: dextroamp-amphetamine ER, dextroamphetamine ER, methylphenidate ER, methylphenidate CD, methylphenidate LA, dexamethasone ER</td>
</tr>
<tr>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
</tbody>
</table>
|       | metolazone | **Covered Uses:** Must meet "1" of the following:  
|       |   | a. Edema  
|       |   | b. Hypertension (HTN)  
|       |   | **Exclusion Criteria:** N/A  
|       |   | **Required Medical Information:** Must meet the following requirement:  
|       |   | a. Failure or clinically significant adverse effects to the following: furosemide  
|       | **Age Restrictions:** N/A | **Prescriber Restrictions:** N/A |
| Mycamine | micafungin | **Covered Uses:** Must meet “1” of the following:  
|       |   | a. Candidemia  
|       |   | b. Esophageal candidiasis  
|       |   | c. Prophylaxis of Candida infection in blood stem cell transplantation  
|       |   | **Exclusion Criteria:** N/A  
|       |   | **Required Medical Information:** Must meet the following requirement:  
|       |   | a. Confirmed diagnosis  
|       | **Age Restrictions:** N/A | **Prescriber Restrictions:** N/A |
| Korlym | mifepristone | **Covered Uses:** Cushing syndrome with type 2 diabetes  
|       |   | **Exclusion Criteria:** N/A  
|       |   | **Required Medical Information:** Must meet all of the following requirements:  
|       |   | a. Failure or clinically significant adverse effects to "2" of the following: acarbose, glimepiride, glipizide, glipizide/metformin, glyburide, glyburide/metformin, Invokana, Invokamet, Steglatro, Segluromet, alogliptin, alogliptin/metformin, metformin or pioglitazone  
|       |   | b. Documented type 2 diabetes or documented glucose intolerance (defined as 2-hr glucose tolerance test glucose value of 140-199mg/dL or fasting glucose value of 100-125 mg/dL)  
|       |   | c. Documentation that patient has failed pituitary surgery or is not a candidate for pituitary surgery  
|       | **Age Restrictions:** N/A | **Prescriber Restrictions:** N/A |
| Myrbetriq | mirabegron | **Covered Uses:** Overactive bladder (OAB)  
|       |   | **Exclusion Criteria:** N/A  
|       |   | **Required Medical Information:** Must meet all of the following requirements:  
|       |   | a. Failure or clinically significant adverse effects to "2" of the alternatives: oxybutynin, oxybutynin ER, tolterodine, OR tolterodine ER  

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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
|       |         | b. Failure or clinically significant adverse effects to "1" of the alternatives: trospium OR trospium ER  
|       |         | Age Restrictions: N/A  
|       |         | Prescriber Restrictions: N/A |
| Mydayis | mixed salts of a single-entity amphetamine | **Covered Uses**: ADHD  
|         |         | **Exclusion Criteria**: N/A  
|         |         | **Required Medical Information**: Must meet the following requirement:  
|         |         | a. Failure or clinically significant adverse effects to TWO formulary stimulants: dexamphetamine, dexamphetamine ER, dextroamp-amphetamine, dextroamp-amphetamine ER, dextroamphetamine, dextroamphetamine ER, methylphenidate, methylphenidate CD, methylphenidate ER, methylphenidate LA, Zensedi  
|         |         | **Age Restrictions**: N/A  
|         |         | **Prescriber Restrictions**: N/A |
|         | modafinil | **Covered Uses**: Must meet "1" of the following:  
|         |         | a. Narcolepsy  
|         |         | b. Obstructive Sleep Apnea  
|         |         | c. Shift work disorder  
|         |         | **Exclusion Criteria**: N/A  
|         |         | **Required Medical Information**: Must meet the following requirement:  
|         |         | a. Confirmed diagnosis  
|         |         | **Age Restrictions**: N/A  
|         |         | **Prescriber Restrictions**: Neurologist, Psychiatrist, Sleep Medicine specialist |
|         | mometasone intranasal | **Covered Uses**: Allergic rhinitis  
|         |         | **Exclusion Criteria**: N/A  
|         |         | **Required Medical Information**: Must meet all of the following requirements:  
|         |         | a. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and Nasacort spray  
|         |         | b. Failure of clinically significant adverse effects to "1" of the following: cetirizine or loratadine  
|         |         | **Age Restrictions**: N/A  
|         |         | **Prescriber Restrictions**: N/A  
|         |         | **Covered Uses**: Nasal polyp  
|         |         | **Required Medical Information**: Must meet the following requirement:  
|         |         | a. Confirmed diagnosis  
|         |         | **Age Restrictions**: N/A  
|         |         | **Prescriber Restrictions**: N/A |
| Dulera | mometasone, formoterol | **Covered Uses**: Asthma  
|         |         | **Exclusion Criteria**: N/A  
|         |         | **Required Medical Information**: Must meet the following requirement:  
|         |         | a. Failure or clinically significant adverse effects to formulary fluticasone propionate/salmeterol inhaler  
|         |         | **Age Restrictions**: N/A  
<p>|         |         | <strong>Prescriber Restrictions</strong>: N/A |</p>
<table>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Age Restriction:</strong> Must be age of 12 and older</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Embeda</td>
<td>morphine sulfate, naltrexone</td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>Moxeza</td>
<td>moxifloxacin 0.5%</td>
<td><strong>Covered Uses:</strong> Bacterial conjunctivitis</td>
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<td></td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet &quot;1&quot; of the following requirements:</td>
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<tr>
<td></td>
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<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: Ciloxan 0.3% ointment, ciprofloxacin 0.3 % drops, erythromycin ointment, Gentak ointment, gentamicin drops, levofloxacin 0.5 % drops, neomycin-polymyxin-gramicidin drops, neomycin-polymyxin-B-dexameth oint, neomycin-polymyxin-hydrocort drop, neomycin-bacitracin-polymyxin oint, neomycin-polymyxin-dexameth drops, ofloxacin 0.3 % drops, polymyxin B sulfate-trimethoprim drops, sulfacetamide 10 % drops, sulfacetamide 10 % ointment, sulfacetamide-prednisolone drops, TobraDex ointment, tobramycin 0.3 % drops, tobramycin-dexamethasone drops, Tobrex 0.3 % ointment or Vigamox 0.5 % drops</td>
</tr>
<tr>
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<td></td>
<td>b. Prescribed by a specialist (e.g. Infectious Disease specialist, Ophthalmologist, Optometrist)</td>
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<tr>
<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
</tr>
<tr>
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<td></td>
<td><strong>Prescriber Restrictions:</strong> See Required Medical Information</td>
</tr>
<tr>
<td>AquADEKs</td>
<td>multivitamin</td>
<td><strong>Covered Uses:</strong> Cystic Fibrosis or Malabsorption disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Movantik</td>
<td>naloxegol</td>
<td><strong>Covered Uses:</strong> Opioid-induced constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Documentation of chronic opioid use in the past 90 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: docusate, fiber or psyllium</td>
</tr>
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<td>c. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: bisacodyl or senna</td>
</tr>
<tr>
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<td></td>
<td>d. Failure or clinically significant adverse effects to &quot;1&quot; of the alternatives: lactulose or polyethylene glycol powder</td>
</tr>
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<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>nano particle albumin-bound paclitaxel</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
<td></td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Covered Uses: Must meet &quot;1&quot; of the following</td>
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<tr>
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<tr>
<td></td>
<td></td>
<td>a. Osteoarthritis</td>
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<tr>
<td></td>
<td></td>
<td>b. Rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion Criteria: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Required Medical Information: Must meet all of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Failure or clinically significant adverse effects to ALL of the alternatives: esomeprazole AND naproxen concurrently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. Failure or clinically significant adverse effects to ONE of the alternatives: etodolac, ibuprofen, indomethacin, meloxicam, nabumetone, piroxicam, sulindac</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. Failure or clinically significant adverse effects to ONE of the alternatives: lansoprazole, omeprazole, pantoprazole OR rabeprazole</td>
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<td></td>
<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td>Prescriber Restrictions: N/A</td>
</tr>
<tr>
<td>Vimovo</td>
<td>naproxen, esomeprazole</td>
<td>Covered Uses: Migraine headache</td>
</tr>
<tr>
<td></td>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;1&quot; of the following: rizatriptan or rizatriptan ODT</td>
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<td>b. Failure or clinically significant adverse effects to the following: sumatriptan</td>
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<td></td>
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<td>Age Restrictions: Must be age of 18 years or older</td>
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<td></td>
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<td>Prescriber Restrictions: N/A</td>
</tr>
<tr>
<td></td>
<td>naratriptan</td>
<td>Covered Uses: Crohn's Disease</td>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
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<td>Required Medical Information: Must meet all of the following requirements:</td>
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<td></td>
<td></td>
<td>a. Must meet &quot;1&quot; of the following requirements:</td>
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<td>i. Failure or clinically significant adverse effects to an adequate course of corticosteroids (e.g. oral budesonide 9mg/day, prednisone 40-60mg daily);</td>
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<td></td>
<td>ii. Documentation that patient has been unable to taper corticosteroid therapy without experiencing worsening of disease;</td>
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<td>b. Treatment with at least a two-month course of DMARD: azathioprine, mercaptopurine or methotrexate, was not effective or not tolerated, unless all are contraindicated;</td>
</tr>
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<td></td>
<td>c. Failure or inadequate response to at least a 3-month treatment course of the preferred biologic therapies (see below), unless each were not tolerated or were contraindicated;</td>
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<tr>
<td></td>
<td></td>
<td>i. Humira</td>
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<td></td>
<td></td>
<td>ii. Cimzia</td>
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<td></td>
<td></td>
<td>iii. Renflexis</td>
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<td>Age Restrictions: N/A</td>
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<td></td>
<td></td>
<td>Prescriber Restrictions: Gastroenterologist</td>
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<tr>
<td></td>
<td>natalizumab</td>
<td>Covered Uses: Relapsing form of multiple sclerosis</td>
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<td></td>
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<td>Exclusion Criteria: N/A</td>
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<td></td>
<td></td>
<td>Required Medical Information: Must meet &quot;1&quot; of the following requirements:</td>
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</table>
|        |                                | a. Failure or clinically significant adverse effects to all of the following:
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Portrazza | necitumumab | i. One glatiramer product and “1” interferon alternative (e.g. Avonex, Betaseron, Extavia, Rebif);  
ii. One oral disease modifying therapy: Aubagio, Gilenya or Tecfidera;  
iii. Ineffectiveness of above therapy is evidenced by one of the following:  
1. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
2. Member continues to have CNS lesion progression as shown in MRI;  
3. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.);  
b. Documented aggressive initial disease course as evidenced by one of the following (please consult IEHP pharmacist):  
i. Multiple (at least two) relapses with incomplete resolution in the past year;  
ii. At least two MRI showing new or enlarging T2 lesions despite treatment over 6 months;  
iii. The presence of spinal or brainstem lesions on MRI  
Age Restrictions: N/A  
Prescriber Restrictions: Neurologist |
| Nevanac   | nepafenac 0.1% | **Covered Uses:** Pain, inflammation associated with cataract surgery  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to “1” of the following: ketorolac 0.4% or ketorolac 0.5%  
b. Failure or clinically significant adverse effects to the following: diclofenac 0.1%  
Age Restrictions: N/A  
Prescriber Restrictions: Ophthalmologist, Optometrist |
| Ilevro    | nepafenac 0.3% | **Covered Uses:** Pain, inflammation associated with cataract surgery  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to “1” of the following: ketorolac 0.4% or ketorolac 0.5%  
b. Failure or clinically significant adverse effects to the following: diclofenac 0.1%  
Age Restrictions: N/A  
Prescriber Restrictions: Ophthalmologist, Optometrist |
| Nerlynx   | neratinib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Tasigna   | nilotinib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
|           | nimodipine | **Covered Uses:** Subarachnoid hemorrhage  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis |
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</table>
| Ofev | nintedanib esylate | **Covered Uses:** Idiopathic Pulmonary Fibrosis  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet all of the following requirements:  
a. The indicated diagnosis (including any applicable labs and/or tests) must be confirmed by the presence of unspecified interstitial pneumonia (UIP) via high-resolution computer tomography (HRCT) and/or surgical lung biopsy  
b. Clinically diagnosed with idiopathic pulmonary fibrosis  
c. Baseline percent predicted forced vital capacity (FVC) greater than or equal to 50% of predicted  
d. Baseline percent predicted diffusing capacity of the lung for carbonmonoxide (DLCO) is between 30 to 79%  
e. Confirmation that the patient is a non-smoker or has abstained from smoking for at least 6 weeks  
**Age Restriction:** N/A  
**Prescriber Restrictions:** Pulmonologist |
| Opdivo | nivolumab | **Covered Uses:** Contraception  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Tried or clinically significant adverse effects to “2” of the following: Azurette, Balziva, Camrese, Caziant, desogestrel-ethinyl estradiol, Gianvi, Junel FE, levonorgestrel- ethinyl estradiol, Leena, Levora, Low-Ogestrel, Microgestin, Mononessa, Necon, norethindrone, NuvaRing, Ocella, Ogestrel, Quasense, Sronyx, Tilia Fe, TriNessa, Trivora, Xulane, Zenchent Fe or Zovia  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Spinraza | nusinersen | **Covered Uses:** |  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
<p>| Adult Nutrition Supplement (e.g. Ensure, Jevity, Glucerna, Osmolite, Boost, etc.) | nutritional supplement | Please refer to Adult Enteral Nutritional Supplement Drug Class Prior Authorization Criteria |
| Infant Formula Nutrition Supplement | nutritional supplement | Please refer to Nutritional Supplement Infant Formula Prior Authorization Criteria |</p>
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
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<tbody>
<tr>
<td>(Nutramigen, Similac Alimentum, Nutramigen Enflora, Elecare Infant, Neocate Infant etc.)</td>
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<tr>
<td>Pediatric Nutritional Supplement (PediaSure, Boost, Nutren Jr, Peptamen Jr, etc.)</td>
<td>nutritional supplement</td>
<td>Please refer to Nutritional Supplement Pediatric Nutritional Supplements Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Ocrevus | ocrelizumab | **Covered Uses**: Must meet "1" of the following:  
a. Primary progressive multiple sclerosis;  
b. Relapsing form of multiple sclerosis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the following requirements:  
a. Primary progressive multiple sclerosis:  
   i. Confirmed diagnosis  
b. Relapsing form of multiple sclerosis:  
   i. Failure or clinically significant adverse effects to all of the following:  
      1. One glatiramer product (glatiramer or Glatopa)  
      2. One interferon alternative (e.g. Avonex Betaseron, Extavia, Rebif);  
      3. One oral disease modifying therapy: Aubagio, Gilenya or Tecfidera;  
   ii. Ineffectiveness of above therapy is evidenced by "1" of the following:  
      1. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
      2. Member continues to have CNS lesion progression as shown in MRI;  
      3. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.);  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Neurologist |
| Sandostatin | octreotide | **Covered Uses**: Acromegaly or Carcinoid or VIPoma  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
<table>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Sandostatin LAR Depot | octreotide       | **Covered Uses**: Acromegaly or Carcinoid or VIPoma  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Confirmed diagnosis  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| Arzerra       | ofatumumab       | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                 |
| Lynparza      | olaparib         | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                 |
| Lartruvo      | olaratumab       | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                 |
|               | olopatadine 0.2% | **Covered Uses**: Allergic conjunctivitis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet "1" of the following requirements:  
  a. Failure or clinically significant adverse effects to "2" of the following: cromolyn, olopatadine, or Zaditor  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: See Required Medical Information |
|               | olopatadine 0.6% intranasal | **Covered Uses**: Allergic rhinitis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to the following: azelastine nasal 0.1%  
  b. Failure or clinically significant adverse effects to all of the following: fluticasone propionate spray and Nasacort spray  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| Pazeo         | olopatadine 0.7% | **Covered Uses**: Allergic conjunctivitis  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet "1" of the following requirements:  
  a. Failure or clinically significant adverse effects to "2" of the following: azelastine, cromolyn, olopatadine, or Zaditor  
  b. Prescribed by an Ophthalmologist or Optometrist  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: See Required Medical Information |
<p>| Synribo       | omacetaxine mepesuccinate | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria                                                 |</p>
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Xolair</td>
<td>omalizumab</td>
<td>Please refer to Xolair Drug Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
|              | omega-3-acid ethyl esters        | **Covered Uses**: Hyperlipidemia, Hypercholesterolemia, Hypertriglyceridemia or Dyslipidemia  
|              |                                  | **Exclusion Criteria**: N/A                                               |
|              |                                  | **Required Medical Information**: Must meet all of the following requirements:  
|              |                                  | a. Failure or clinically significant adverse effects to "1" of the following: fenofibrate tablet, fenofibrate micronized capsule, fenofibrate nanocrystallized tablet, fenofibric acid capsule or gemfibrozil  
|              |                                  | b. Documented triglyceride level of 500mg/dL or greater                   |
|              |                                  | **Age Restrictions**: N/A                                                 |
|              |                                  | **Prescriber Restrictions**: N/A                                          |
| Prilosec Granule | omeprazole suspension            | **Covered Uses**: Must meet "1" of the following:  
|              |                                  | a. Barrett’s esophagus                                                  |
|              |                                  | b. Erosive esophagitis                                                  |
|              |                                  | c. Duodenal ulcer disease                                               |
|              |                                  | d. Gastric ulcer                                                        |
|              |                                  | e. H. pylori infection                                                  |
|              |                                  | f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome) |
|              |                                  | g. NSAID associated gastric ulcer                                        |
|              |                                  | h. Symptomatic GERD                                                    |
|              |                                  | **Exclusion Criteria**: N/A                                               |
|              |                                  | **Required Medical Information**: Must meet all of the following requirements:  
|              |                                  | a. ONE of the following:                                                |
|              |                                  | i. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, omeprazole, esomeprazole DR, pantoprazole AND rabeprazole  
|              |                                  | ii. Documented difficulty swallowing AND Failure or clinically significant adverse effects to ALL of the alternatives:  
|              |                                  | omeprazole capsule AND lansoprazole capsule sprinkled on apple sauce or juice as directed per package insert  
|              |                                  | iii. Documented tube feeding                                             |
|              |                                  | b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia. |
|              |                                  | **Age Restrictions**: N/A                                                 |
|              |                                  | **Prescriber Restrictions**: N/A                                          |
|              | omeprazole, sodium bicarbonate   | **Covered Uses**: Must meet "1" of the following:  
|              |                                  | a. Barrett’s esophagus                                                  |
|              |                                  | b. Erosive esophagitis                                                  |
|              |                                  | c. Duodenal ulcer disease                                               |
|              |                                  | d. Gastric ulcer                                                        |
|              |                                  | e. H. pylori infection                                                  |
|              |                                  | f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome) |
|              |                                  | g. NSAID associated gastric ulcer                                        |
|              |                                  | h. Symptomatic GERD                                                    |
|              |                                  | **Exclusion Criteria**: N/A                                               |
|              |                                  | **Required Medical Information**: Must meet all of the following requirements:  
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<tr>
<th>Brand</th>
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<th>Criteria</th>
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</table>
| Botox      | onabotulinum toxin A | a. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, esomeprazole DR, omeprazole, pantoprazole AND rabeprazole  
  b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A                                                                 |
| Botox Cosmetic | onabotulinum toxin A | **Covered Uses:** N/A  
  **Exclusion Criteria:** Not a covered benefit  
  **Required Medical Information:** N/A  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A                                                                 |
| Alli       | orlistat        | **Covered Uses:** Obesity  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet “1” of the following requirements:  
  a. BMI greater than or equal to 30 kilograms per meter squared.  
  b. BMI greater than or equal to 27 kilograms per meter squared with a comorbidity. A comorbidity is defined as but not limited to “1” of the following:  
  i. Diabetes Mellitus Type II  
  ii. Coronary Heart Disease  
  iii. Hyperlipidemia  
  iv. Hypertension  
  v. Sleep Apnea  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A                                                                 |
| orphenadrine |                  | **Covered Uses:** Treatment of acute, painful musculoskeletal condition (e.g. neck pain, low back pain)  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "2" of the following: cyclobenzaprine, methocarbamol or tizanidine  
  **Age Restrictions:** N/A  
  **Prescriber Restrictions:** N/A                                                                 |
| Tagrisso   | osimertinib     | **Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria**                                                                                                                     |
| oxazepam   |                  | **Covered Uses:** Anxiety  
  **Exclusion Criteria:** N/A  
  **Required Medical Information:** Must meet the following requirement:
<table>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td></td>
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<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the alternatives: alprazolam, clonazepam, diazepam OR lorazepam</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<td></td>
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<td><strong>Covered Uses:</strong> Alcohol withdrawal syndrome</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Oxtellar XR</td>
<td>oxcarbazepine ER</td>
<td><strong>Covered Uses:</strong> Seizure</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<td></td>
<td></td>
<td>a. Must use concurrently with at least ONE other anticonvulsant medication</td>
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<td></td>
<td>b. Failure or clinically significant adverse effects to the alternative: oxcarbazepine</td>
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<td></td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
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<td><strong>Prescriber Restrictions:</strong> Neurologist</td>
</tr>
<tr>
<td>oxycodone</td>
<td>oxycodone ER</td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td>IR</td>
<td></td>
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<tr>
<td>Xtampza ER</td>
<td>oxycodone myristate</td>
<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
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<tr>
<td>oxymorphone</td>
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<td>Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Ibrance</td>
<td>palbociclib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Synagis</td>
<td>palivizumab</td>
<td>Please refer to Synagis (Palivizumab) Drug Prior Authorization Criteria</td>
</tr>
<tr>
<td>Zenpep</td>
<td>pancrelipase</td>
<td><strong>Covered Uses:</strong> Pancreatic insufficiency</td>
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<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td></td>
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<td>a. Failure or clinically significant adverse effects to the alternative: Creon</td>
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<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
|             |                                  | Age Restrictions: N/A  
Prescriber Restrictions: N/A                                              |
| Vectibix    | panitumumab                      | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Farydak     | panobinostat lactate             | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Protonix Granules | pantoprazole DR granules for suspension                                  | **Covered Uses:** Must meet "1" of the following:  
  a. Barrett's esophagus  
b. Erosive esophagitis  
c. Duodenal ulcer disease  
d. Gastric ulcer  
e. H. pylori infection  
f. Gastric hypersecretion (Zollinger Ellison syndrome, Retained Gastric Antrum syndrome)  
g. NSAID associated gastric ulcer  
h. Symptomatic GERD  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. ONE of the following:  
i. Failure or clinically significant adverse effects to ALL of the alternatives: lansoprazole, omeprazole, esomeprazole DR, pantoprazole AND rabeprazole  
  ii. Documented difficulty swallowing AND Failure or clinically significant adverse effects to ALL of the alternatives: omeprazole capsule AND lansoprazole capsule sprinkled on apple sauce or juice as directed per package insert  
  iii. Documented tube feeding  
b. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| paroxetine ER |                                  | **Covered Uses:** Must meet "1" of the following:  
a. Major Depressive Disorder  
b. Panic Disorder  
c. Social Anxiety Disorder  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary paroxetine  
b. Failure or clinically significant adverse effects to at least a 6-week treatment course of "1" additional formulary antidepressant alternative citalopram, escitalopram, fluoxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER OR mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Psychiatrist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Premenstrual Dysphoric Disorder</td>
<td>Exclusion Criteria: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
<td>Required Medical Information: Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to formulary paroxetine and &quot;1&quot; additional formulary antidepressant alternative fluoxetine, paroxetine, OR sertraline</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age Restrictions: N/A</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Prescriber Restrictions: Psychiatrist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pexeva</th>
<th>paroxetine mesylate</th>
<th>Must meet &quot;1&quot; of the following:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Major depressive disorder;</td>
<td>b. Obsessive compulsive disorder;</td>
<td>c. Panic disorder</td>
</tr>
<tr>
<td></td>
<td>Exclusion Criteria: N/A</td>
<td>Required Medical Information: Must meet all of the following requirements:</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary paroxetine</td>
<td>b. Failure or clinically significant adverse effects to at least a 6-week treatment course of &quot;1&quot; additional formulary antidepressant alternative citalopram, escitalopram, fluoxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER OR mirtazapine</td>
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<td></td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: Psychiatrist</td>
<td></td>
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<tr>
<td></td>
<td>Covered Uses: Generalized anxiety disorder</td>
<td>Exclusion Criteria: N/A</td>
<td></td>
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<tr>
<td></td>
<td>Required Medical Information: Must meet all of the following requirements:</td>
<td>Prescriber Restrictions: Psychiatrist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Failure or clinically significant adverse effects to at least a 6-week treatment course of formulary paroxetine</td>
<td>Required Medical Information:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Failure or clinically significant adverse effects to at least &quot;1&quot; additional formulary alternative buspirone, escitalopram, OR duloxetine DR</td>
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<td></td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: Psychiatrist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered Uses: Cushing syndrome</td>
<td>Exclusion Criteria: N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Required Medical Information: Must meet the following requirement:</td>
<td>Age Restrictions: N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Confirmed diagnosis</td>
<td>Prescriber Restrictions: Endocrinologist</td>
<td></td>
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<tr>
<td></td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: Endocrinologist</td>
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<table>
<thead>
<tr>
<th>Signifor</th>
<th>pasireotide diaspertate</th>
<th>Cushing syndrome</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Required Medical Information: Must meet the following requirement:</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>a. Confirmed diagnosis</td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: Endocrinologist</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<td>--------------------------------------------------------------------------</td>
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</tbody>
</table>
| Signifor LAR| pasireotide pamoate   | **Covered Uses:** Acromegaly<br>**Exclusion Criteria:** N/A <br>**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to Sandostatin LAR depot<br>**Age Restrictions:** N/A <br>**Prescriber Restrictions:** Endocrinologist |
|             |                       | **Covered Uses:** Cushing syndrome<br>**Exclusion Criteria:** N/A <br>**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis<br>**Age Restrictions:** N/A <br>**Prescriber Restrictions:** Endocrinologist |
|             |                       | **Covered Uses:** Hyperkalemia<br>**Exclusion Criteria:** N/A <br>**Required Medical Information:** Must meet the following requirement:  
a. Documentation of Chronic Kidney Disease (CKD)<br>**Age Restrictions:** N/A <br>**Prescriber Restrictions:** Endocrinologist, Nephrologist |
| Votrient    | pazopanib             | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Macugen     | pegaptanib            | **Covered Uses:** Neovascular (Wet) Age related macular degeneration<br>**Exclusion Criteria:** N/A <br>**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis<br>**Age Restrictions:** N/A <br>**Prescriber Restrictions:** Ophthalmologist |
| Oncaspar    | pegaspargase          | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Neulasta    | pegfilgrastim         | **Covered Uses:** Must meet "1" of the following:  
a. Prevention of chemotherapy-induced neutropenia<br>b. Hematopoietic radiation injury syndrome (acute)<br>**Exclusion Criteria:** N/A <br>**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "1" of the following: Granix or Zarxio<br>**Age Restrictions:** N/A <br>**Prescriber Restrictions:** Hematologist, Oncologist or HIV/Infectious Disease specialist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylatron</td>
<td>peginterferon alfa-2b</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Plegridy| peginterferon beta-1A  | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: glatiramer or Glatopa; as evidenced by at least “1” of the following:  
   i. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
   ii. Member continues to have CNS lesion progression as shown in MRI;  
   iii. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.).  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Krystexxa| pegloticase IV         | **Covered Uses:** Gout  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documentation of “1” of the following requirements:  
   i. 3 or more gout flares in the previous 18 months  
   ii. 1 or more tophus  
   iii. History of chronic gouty arthropathy OR established joint damage due to gout  
b. Documented uric acid level of 6mg/dL or greater  
c. Failure or clinically significant adverse effects to all of the following: allopurinol and Uloric  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
| Keytruda| pembrolizumab          | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| FYCOMPA | perampanel            | **Covered Uses:** Seizure (i.e. partial-onset seizure, primary generalized tonic-clonic seizure)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to "2" of the alternatives: carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate or zonisamide.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist (new start) |
<p>| Perjeta | pertuzumab             | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |</p>
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses: Obesity</th>
<th>Exclusion Criteria: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>phentermine</td>
<td></td>
<td><strong>Required Medical Information</strong>: Must meet “1” of the following requirements:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. BMI greater than or equal to 30 kilograms per meter squared.</td>
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<tr>
<td></td>
<td></td>
<td>b. BMI greater than or equal to 27 kilograms per meter squared with a comorbidity. A</td>
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<td></td>
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<td>comorbidity is defined as but not limited to “1” of the following:</td>
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<tr>
<td></td>
<td></td>
<td>i. Diabetes Mellitus Type II</td>
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<tr>
<td></td>
<td></td>
<td>ii. Coronary Heart Disease</td>
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<td></td>
<td></td>
<td>iii. Hyperlipidemia</td>
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<td></td>
<td></td>
<td>iv. Hypertension</td>
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<tr>
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<td>v. Sleep Apnea</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
<td></td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
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</tbody>
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<table>
<thead>
<tr>
<th>pimecrolimus topical cream</th>
<th>Covered Uses: Atopic dermatitis (i.e. eczema)</th>
<th>Exclusion Criteria: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Required Medical Information</strong>: Must meet all</td>
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<tr>
<td></td>
<td>of the following requirements:</td>
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<tr>
<td></td>
<td>a. Failure or clinically significant adverse</td>
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<td></td>
<td>effects to “2” of the alternatives:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>betamethasone dipropionate 0.05% (lotion,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ointment, cream), betamethasone valerate 0.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ointment, cream), clobetasol 0.05% (ointment,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cream, foam, gel, solution), clobetasol-</td>
<td></td>
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<tr>
<td></td>
<td>emollient 0.05 % topical cream, fluocinolone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.025% (cream, ointment), fluocinonide 0.05%</td>
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</tr>
<tr>
<td></td>
<td>(cream, gel, ointment, solution), fluorocinone-</td>
<td></td>
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<tr>
<td></td>
<td>E 0.05 % topical cream, mometasone 0.1% (ointment,</td>
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<tr>
<td></td>
<td>cream, solution), triamcinolone 0.1% (cream,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ointment, lotion), OR triamcinolone 0.5% (ointment,</td>
<td></td>
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<tr>
<td></td>
<td>cream)</td>
<td></td>
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<tr>
<td></td>
<td>b. Failure or clinically significant adverse</td>
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<tr>
<td></td>
<td>effects to the alternative: tacrolimus ointment</td>
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<tr>
<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
<td></td>
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<tr>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
<td></td>
</tr>
</tbody>
</table>

| piperacillin, tazobactam   | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |

<table>
<thead>
<tr>
<th>Esbriet</th>
<th>pirfenidone</th>
<th>Covered Uses: Idiopathic Pulmonary Fibrosis</th>
<th>Exclusion Criteria: CCS eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information</strong>: Must meet all of the following requirements:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>a. The indicated diagnosis (including any applicable labs and/or tests) and</td>
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<td></td>
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<td>medication usage must be supported by documentation from the patient’s medical</td>
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<td></td>
<td></td>
<td>record)</td>
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<tr>
<td></td>
<td></td>
<td>b. Clinically diagnosed with idiopathic pulmonary fibrosis</td>
<td></td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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</tr>
</tbody>
</table>
|       |         | c. Baseline percent predicted forced vital capacity (FVC) greater than or equal to 50% of predicted  
d. Baseline percent predicted diffusing capacity of the lung for carbon monoxide (DLCO) is between 30 to 90%  
e. Confirmation that the patient is a non-smoker or has abstained from smoking for at least 6 weeks  
**Age Restriction:** N/A  
**Prescriber Restrictions:** Pulmonologist |
| Pomalyst | pomalidomide | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Iclusig | ponatinib | Covered Uses: Nephrolithiasis (kidney calculus, hypocitraturia)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Folotyn | pralatrexate | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
|       | pramipexole ER | Covered Uses: Parkinson’s disease  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “1” of the following: pramipexole or ropinirole  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
|       | pregabalin | Covered Uses: Seizure  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet the following requirement:  
a. Documented concurrent use with at least one other anticonvulsant medication  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist  
**Covered Uses:** Neuropathic pain associated with spinal cord injury  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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</thead>
</table>
|       |         | **Covered Uses:** Fibromyalgia or neuropathic pain  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to amitriptyline within the past 6 months  
b. Failure or clinically significant adverse effects to gabapentin greater than or equal to 1200mg/day within the past 6 months  
b. Must meet "1" of the following:  
   1. Failure or clinically significant adverse effects to venlafaxine within the past 6 months  
   2. Failure or clinically significant adverse effects to duloxetine within the past 6 months  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|       |         | **Covered Uses:** Postherpetic neuralgia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to ALL of the alternatives: amitriptyline and gabapentin greater than or equal to 1200mg/day  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| protriptyline |         | **Covered Uses:** Depression  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to "1" of the alternatives: amitriptyline, desipramine, doxepin, imipramine OR nortriptyline  
b. Failure or clinically significant adverse effects to "1" of the alternatives: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, bupropion OR mirtazapine  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Psychiatrist |
| Xofigo | radium-223 dichloride | **Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria** |
| Rozerem | ramelteon | **Covered Uses:** Insomnia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet "1" of the following requirements:  
a. Documentation of history of substance abuse  
b. Must meet all of the following requirements:  
i. Failure or clinically significant adverse effects to the following: zolpidem  
ii. Failure or clinically significant adverse effects to "1" of the following: eszopiclone or zaleplon |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Cyramza</td>
<td>ramucirumab</td>
<td><strong>Covered Uses:</strong> Neovascular (Wet) Age related macular degeneration, Macular edema with retinal vein occlusion, Choroidal retinal neovascularization, Diabetic macular edema OR Diabetic retinopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Ophthalmologist</td>
</tr>
<tr>
<td>Lucentis</td>
<td>ranibizumab</td>
<td><strong>Covered Uses:</strong> Neovascular (Wet) Age related macular degeneration, Macular edema with retinal vein occlusion, Choroidal retinal neovascularization, Diabetic macular edema OR Diabetic retinopathy</td>
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<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Ophthalmologist</td>
</tr>
<tr>
<td>Ranexa</td>
<td>ranolazine</td>
<td><strong>Covered Uses:</strong> Chronic angina pectoris</td>
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<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to “1” drug from any “2” of the groups:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Atenolol, carvedilol, labetalol, metoprolol succinate, metoprolol tartrate, propranolol or sotalol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. Amlodipine, diltiazem, diltiazem CD, diltiazem ER, felodipine ER, nifedipine, nifedipine ER, Taztia XT, verapamil, or verapamil ER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. Isordil, isosorbide dinitrate, isosorbide ER or Nitro-bid</td>
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<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Cardiologist (new start)</td>
</tr>
<tr>
<td>Rasagiline</td>
<td>rasagiline</td>
<td><strong>Covered Uses:</strong> Parkinson’s disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to selegiline and “1” of the following: carbidopa/levodopa, carbidopa/levodopa ER, pramipexole, ropinirole</td>
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<tr>
<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Neurologist</td>
</tr>
<tr>
<td>Stivarga</td>
<td>regorafenib</td>
<td><strong>Covered Uses:</strong> Must meet “1” of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Rho(D) suppression: antepartum prophylaxis</td>
</tr>
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<td>b. Rho(D) suppression: following potentially sensitizing event (e.g. trauma, invasive procedures or obstetric complications)</td>
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<td></td>
<td>c. Transfusion of Rh-incompatible blood or blood products</td>
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<td></td>
<td></td>
<td>d. Rho(D) suppression: postpartum prophylaxis</td>
</tr>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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</tbody>
</table>

RhoGAM | Rh0 [D] immune globulin | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xifaxan</td>
<td>rifaximin</td>
<td><strong>Covered Uses:</strong> Irritable bowel syndrome with diarrhea (IBS-D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to ALL of the</td>
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<tr>
<td></td>
<td></td>
<td>following alternatives: loperamide AND dicyclomine</td>
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<td></td>
<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Gastroenterologist</td>
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<td></td>
<td></td>
<td><strong>Covered Uses:</strong> Hepatic encephalopathy; Prophylaxis</td>
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<tr>
<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to lactulose</td>
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<td></td>
<td><strong>Age Restrictions:</strong> N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Gastroenterologist, Hepatologist</td>
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<tr>
<td></td>
<td></td>
<td><strong>Covered Uses:</strong> Traveler’s diarrhea</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to ciprofloxacin</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Myobloc</td>
<td>rimabotulinum toxin B</td>
<td><img src="#" alt="Please refer to Botulinum Toxin Drug Class Prior Authorization Criteria" /></td>
</tr>
<tr>
<td>Adempas</td>
<td>riociguat</td>
<td><strong>Covered Uses:</strong> Pulmonary Arterial Hypertension</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria:</strong> N/A</td>
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<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following</td>
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<tr>
<td></td>
<td></td>
<td>requirements:</td>
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<td></td>
<td></td>
<td>a. Documented WHO Functional Class II or above</td>
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<td></td>
<td></td>
<td>b. Failure or clinically significant adverse effect to sildenafil</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
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<tr>
<td>-</td>
<td>risedronate</td>
<td><strong>Covered Uses:</strong> Must meet &quot;1&quot; of the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. Osteoporosis</td>
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<td></td>
<td></td>
<td>b. Paget’s Disease</td>
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<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Exclusion Criteria: N/A</th>
<th>Required Medical Information: Must meet the following requirement:</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to alendronate.</td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: N/A</td>
</tr>
<tr>
<td>Rituxan</td>
<td>rituximab</td>
<td>Covered Uses: Cancer indications (e.g. chronic lymphocytic leukemia, non-Hodgkin lymphoma)</td>
<td>Exclusion Criteria: CCS eligible</td>
<td>Required Medical Information: Must meet the following requirement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. FDA labeled indication or NCCN recommended regimen of 2B or above</td>
<td>Age Restrictions: N/A</td>
<td>Prescriber Restrictions: Hematologist, Oncologist</td>
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<tr>
<td></td>
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<td>Must meet all of the following requirements:</td>
<td></td>
<td>Covered Uses: Idiopathic Thrombocytopenic Purpura (ITP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Must meet &quot;1&quot; of the following:</td>
<td></td>
<td>Exclusion Criteria: CCS eligible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Platelet count is less than 20,000 per cubic meter</td>
<td>Required Medical Information:</td>
<td>Age Restrictions: N/A</td>
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<td></td>
<td></td>
<td>ii. Platelet count is less than 30,000 per cubic meter with symptoms of bleeding</td>
<td>a. Failure or clinically significant adverse effects to corticosteroid therapy</td>
<td>Prescriber Restrictions: Hematologist</td>
</tr>
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<td></td>
<td></td>
<td>b. Failure or clinically significant adverse effects to corticosteroid therapy</td>
<td></td>
<td>Covered Uses: Rheumatoid Arthritis (RA)</td>
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<td></td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>Exclusion Criteria: N/A</td>
<td>Required Medical Information: Must meet all of the following requirements:</td>
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<tr>
<td></td>
<td></td>
<td>Prescriber Restrictions: Immunologist, Oncologist, Rheumatologist</td>
<td>a. Failure or clinically significant adverse effects to &quot;1&quot; of the following: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, OR sulfasalazine</td>
<td>Covered Uses: Must meet &quot;1&quot; of the following:</td>
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<tr>
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<td>b. Failure or clinically significant adverse effects to ALL of the following: Enbrel AND Humira</td>
<td>a. Granulomatosis with Polyangitis (GPA): Wegener’s Granulomatosis</td>
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<tr>
<td></td>
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<td>Age Restrictions: N/A</td>
<td></td>
<td>b. Microscopic polyangiitis/polyarteritis (MPA)</td>
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<td></td>
<td>Prescriber Restrictions: Immunologist, Rheumatologist</td>
<td>Exclusion Criteria: N/A</td>
<td>Required Medical Information: Must meet the following requirement:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
<td>Age Restrictions: N/A</td>
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<td></td>
<td></td>
<td></td>
<td>Prescriber Restrictions: Immunologist, Rheumatologist</td>
<td></td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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</tbody>
</table>
| Xarelto 10mg, | rivaroxaban| **Code 1 Criteria**: Deep Venous Thrombosis (DVT) and/or Pulmonary Embolism (PE)  
**Code 1 Criteria**: Prophylaxis DVT following hip or knee replacement surgery  
**Covered Uses**: Non-Valvular Atrial Fibrillation (AFib)  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to warfarin  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| 15mg, 20mg    |            |                                                                                                                                                                                                 |
| Xarelto 2.5mg | rivaroxaban| **Covered Uses**: Coronary Artery Disease (CAD) or peripheral artery disease (PAD)  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet all of the following requirements:  
  a. Documentation of concurrent use with aspirin  
  b. Documentation of "1" of the following:  
    i. Atherosclerosis involving at least two vascular beds  
    ii. Atherosclerosis with at least "2" additional cardiovascular risks: current smoking, diabetes mellitus, impaired renal function of GFR less than 60 mL per minute, heart failure or history of ischemic stroke  
    iii. Peripheral arterial disease with "1" of the following:  
      1. Symptomatic with ankle brachial index (ABI) less than 0.90  
      2. Asymptomatic carotid artery stenosis greater than or equal to 50%  
      3. History of carotid revascularization procedure  
      4. Ischemic disease of one or both lower extremities  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
|               |            |                                                                                                                                                                                                 |
| rivastigmine  |            | **Covered Uses**: Alzheimer dementia  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet “1” of the following:  
  a. Failure or clinically significant adverse effects to “2” of the following: donepezil, donepezil ODT, rivastigmine capsule, galantamine tablet  
  b. Must meet ALL of the following requirements:  
    i. Documented difficulty swallowing (i.e. dysphagia)  
    ii. Failure or clinically significant adverse effects to formulary donepezil ODT  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| patch         |            |                                                                                                                                                                                                 |
|               |            | **Covered Uses**: Parkinson’s disease dementia  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet “1” of the following:  
  a. Failure or clinically significant adverse effects to rivastigmine capsule  
  b. Documented difficulty swallowing (i.e. dysphagia) |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Daliresp  | roflumilast | **Covered Uses:** Chronic obstructive pulmonary disease (COPD)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. FEV1 less than 50%  
  b. Failure or clinically significant adverse effects to "1" of the following: Incruse Ellipta or Tudorza  
  c. Failure or clinically significant adverse effects to "1" of the following: Advair Diskus, Breo Ellipta or Symbicort  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Allergist, Immunologist, Pulmonologist |
| Nplate    | romiplostim | **Covered Uses:** Chronic immune thrombocytopenia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Must meet "1" of the following requirements:  
    i. Failure or clinically significant adverse effects to "1" of the following: dexamethasone, hydrocortisone, methylprednisolone, prednisone or prednisolone  
    ii. Failure or clinically significant adverse effects to "1" of the following: intravenous immune globulins (IVIG) or WinRho  
    iii. Documented relapse after splenectomy  
    iv. Documented contraindication to splenectomy  
  b. Must meet "1" of the following requirements:  
    i. Documentation platelet count is less than 30 x 10^9/L  
    ii. Must meet all of the following requirements:  
      1. Documentation platelet count is less than 50 x 10^9/L  
      2. Documentation of "1" clinical condition increasing the risk for bleeding: active bleeding, hypertension, peptic ulcer disease, recent surgery, trauma or being on anticoagulation therapy  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Hematologist |
| ropinirole XL |          | **Covered Uses:** Parkinson’s disease  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "1" of the following: pramipexole or ropinirole  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
<table>
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<tr>
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<th>Covered Uses</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Neupro | rotigotine transdermal patch | Parkinson’s disease | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Failure or clinically significant adverse effects to “2” of the following: pramipexole and ropinirole  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist |
| Banzel | rufinamide | Seizure (i.e. Lennox-Gastaut syndrome) | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Must use concurrently with at least "1" other anticonvulsant medication  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist (new start) |
| Jakafi | ruxolitinib | Chronic Heart Failure | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documentation of New York Heart Association (NYHA) class II, III or IV heart failure symptoms  
b. Documented left ventricular ejection fraction less than 40 percent  
**Age Restrictions:** Must be age of 18 or older  
**Prescriber Restrictions:** Cardiologist |
| Entresto | sacubitril, valsartan | Phenylketonuria (PKU) | **Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Geneticist, Metabolic Disorder specialist |
| Kuvan | sapropterin | Rheumatic and Inflammatory Diseases | **Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Geneticist, Metabolic Disorder specialist |
<p>| Kevzara | sarilumab | Rheumatic and Inflammatory Diseases | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria |</p>
<table>
<thead>
<tr>
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<th>Covered Uses</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Onglyza</td>
<td>saxagliptin</td>
<td>Diabetes Mellitus Type II</td>
<td>Exclusion Criteria: N/A &lt;br&gt; Required Medical Information: Must meet all of the following requirements: &lt;br&gt; a. Failure or clinically significant adverse effects to all of the following: &lt;br&gt;   i. Metformin. &lt;br&gt;   ii. &quot;1&quot; of the formulary DPP-4 inhibitor products: alogliptin, alogliptin-metformin &lt;br&gt;   iii. &quot;1&quot; additional oral formulary alternatives: acarbose, glimepiride, glipizide, glipizide/metformin, glyburide, glyburide/metformin, Invokana, Invokamet, Steglatro, Segluromet or pioglitazone &lt;br&gt; b. Documented HbA1c greater than 7 percent after 90 consecutive days of optimal therapy with the tried alternatives. &lt;br&gt; Age Restrictions: N/A &lt;br&gt; Prescriber Restrictions: N/A</td>
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<tr>
<td>Hizentra (SCIG)</td>
<td>SCIG</td>
<td>Immunoglobulin (IVIG) Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Cosentyx</td>
<td>secukinumab</td>
<td>Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Uptravi</td>
<td>selexipag</td>
<td>Pulmonary Arterial Hypertension</td>
<td>Exclusion Criteria: N/A &lt;br&gt; Required Medical Information: Must meet all of the following requirements: &lt;br&gt; a. Documented WHO Functional Class II or above &lt;br&gt; b. Failure or clinically significant adverse effect to sildenafil &lt;br&gt; c. Failure or clinically significant adverse effect to Letairis, Opsumit or Tracleer &lt;br&gt; Age Restrictions: N/A &lt;br&gt; Prescriber Restrictions: Cardiologist, Pulmonologist</td>
</tr>
<tr>
<td></td>
<td>sevelamer powder packet</td>
<td>Chronic Kidney Disease (CKD): stage 3 to 5</td>
<td>Exclusion Criteria: N/A &lt;br&gt; Required Medical Information: Must meet all of the following requirements: &lt;br&gt; a. Documented high phosphate levels (greater than 4.5mg/dL) &lt;br&gt; b. Must meet &quot;1&quot; of the following requirements: &lt;br&gt;   i. Documentation of difficulty swallowing &lt;br&gt;   ii. Documentation of administration via feeding tube &lt;br&gt;   iii. Patient has difficulty with adherence due to pill burden after trial of calcium acetate, Renagel tablet or Renvela tablet &lt;br&gt; Age Restrictions: N/A &lt;br&gt; Prescriber Restrictions: N/A</td>
</tr>
<tr>
<td></td>
<td>sildenafil 20mg tablet</td>
<td>Pulmonary Arterial Hypertension</td>
<td>Exclusion Criteria: N/A &lt;br&gt; Required Medical Information: Must meet the following requirement: &lt;br&gt; a. Documented WHO Functional Class II or above &lt;br&gt; Age Restrictions: N/A</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<td><strong>Prescriber Restrictions</strong>: Cardiologist, Pulmonologist</td>
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<td></td>
<td></td>
<td><strong>Covered Uses</strong>: N/A</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: Erectile dysfunction (ED): Not a covered benefit</td>
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<td><strong>Required Medical Information</strong>: N/A</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td>Sylvant</td>
<td>siltuximab</td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
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<tr>
<td>sirolimus</td>
<td></td>
<td><strong>Covered Uses</strong>: Must meet &quot;1&quot; of the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. Prophylaxis of organ rejection in transplant (e.g. Graft-Versus-Host Disease or GVHD)</td>
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<td></td>
<td></td>
<td>b. Treatment of lymphangioleiomyomatosis</td>
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<td><strong>Exclusion Criteria</strong>: CCS eligible</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<td><strong>Prescriber Restrictions</strong>: Transplant specialist</td>
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<tr>
<td>sodium ferric gluconate complex</td>
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<td><strong>Covered Uses</strong>: Iron-deficiency anemia, hemodialysis-dependent patients</td>
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<td></td>
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<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
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<td></td>
<td><strong>Age Restrictions</strong>: N/A</td>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Covered Uses</strong>: Iron-deficiency anemia, non-dialysis-dependent patient</td>
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<td></td>
<td></td>
<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet &quot;1&quot; of the following requirements:</td>
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<td></td>
<td>a. Failure or clinically significant adverse effects to the following: ferrous sulfate tablet</td>
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<td>b. Documentation that disorder of the GI (e.g. inflammatory bowel disease) may be aggravated by oral iron</td>
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<td></td>
<td>c. Documentation of decreased absorption of oral iron due to gastric bypass surgery and/or subtotal gastric resection</td>
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<td>d. Documentation that oral iron cannot compensate the severe anemia</td>
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<td><strong>Age Restrictions</strong>: N/A</td>
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<td><strong>Prescriber Restrictions</strong>: N/A</td>
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<tr>
<td></td>
<td></td>
<td><strong>Covered Uses</strong>: Chemotherapy-induced anemia</td>
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<td><strong>Exclusion Criteria</strong>: N/A</td>
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<td><strong>Required Medical Information</strong>: Must meet the following requirement:</td>
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<td></td>
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<td>a. Confirmed diagnosis</td>
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<tr>
<td>Euflexxa</td>
<td>sodium hyaluronate</td>
<td>Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria</td>
<td></td>
</tr>
<tr>
<td>Hyalgan</td>
<td>sodium hyaluronate</td>
<td>Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria</td>
<td></td>
</tr>
<tr>
<td>Supartz</td>
<td>sodium hyaluronate</td>
<td>Please refer to Viscosupplementation Product Drug Class Prior Authorization Criteria</td>
<td></td>
</tr>
</tbody>
</table>
| Xyrem     | sodium oxybate | **Covered Uses:** Narcolepsy  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documented daily periods of irrepresible need to sleep or daytime lapses into sleep occurring for at least 3 months  
b. Documentation of sleep study (e.g. MSLT) confirming the diagnosis of narcolepsy and excluding other causes of chronic daytime sleepiness  
c. Documentation of functional impairment due to narcolepsy which may include but not limited to limitation of daily living activities  
d. Failure or clinically significant adverse effects to modafinil AND at least "1" other alternative: amphetamine-dextroamphetamine (Adderall) OR methylphenidate  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist, Psychiatrist |
| sodium phenylbutyrate | **Covered Uses:** Hyperammonemia for the chronic management of urea cycle disorder  
**Exclusion Criteria:** CCS eligible  
**Required Medical Information:** Must meet the following requirement:  
a. Documentation of concurrent dietary protein restriction with or without amino acid supplementation (e.g. Cyclinex, EAA OR UCD I&II)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Covered Uses</th>
<th>Required Medical Information</th>
<th>Exclusion Criteria</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suprep Bowel Prep Kit</td>
<td>sodium sulfate, potassium sulfate, magnesium sulfate</td>
<td>Bowel cleansing before colonoscopy</td>
<td>Must meet the following requirement:</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Vosevi</td>
<td>sofosbuvir, velpatasvir, voxilaprevir</td>
<td>Overactive bladder (OAB)</td>
<td>Must meet all of the following requirements:</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Vesicare</td>
<td>solifenacin</td>
<td></td>
<td>a. Failure or clinically significant adverse effects to “2” of the alternatives: GaviLyte-G, peg 3350-electrolytes OR TriLyte</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Genotropin</td>
<td>somatropin</td>
<td></td>
<td>b. Failure or clinically significant adverse effects to “1” of the alternatives: trospium OR trospium ER</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Humatrope</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Norditropin</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Nutropin</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Saizen</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Serostim</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Zorbtive</td>
<td>somatropin</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Omnitrope vial</td>
<td>somatropin vial</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Odomzo</td>
<td>sonidegib</td>
<td></td>
<td>Age Restrictions: N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Brand</td>
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<td>Criteria</td>
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<tr>
<td>Nexavar</td>
<td>sorafenib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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</tbody>
</table>
| Velphoro   | sucroferric oxyhydroxide | **Covered Uses:** Chronic Kidney Disease (CKD): stage 3 to 5  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Documented high phosphate levels (greater than 4.5mg/dL)  
  b. Failure or clinically significant adverse effects to "1" of the following: Renagel or Renvela  
  c. Must meet "1" of the following requirements:  
     i. Failure or clinically significant adverse effects to the following: calcium acetate  
     ii. Elevated corrected calcium level greater than 9.5 mg/dL  
     iii. Low iPTH level (below laboratory reference range) with normal or elevated serum calcium associated with  
     adynamic bone disease  
     iv. Documentation of vascular calcification  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|            | sumatriptan injectable | **Covered Uses:** Migraine headache  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to the alternative: sumatriptan tablet  
  b. Failure or clinically significant adverse effects to "1" of the alternative: rizatriptan or rizatriptan ODT  
  c. Must use concurrently with "1" of the following for migraine prophylaxis: amitriptyline, atenolol, divalproex, metoprolol, propranolol, topiramate, valproate or venlafaxine  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
|            | sumatriptan intranasal spray 20mg, 5mg | **Covered Uses:** Migraine headache  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to the alternative: sumatriptan  
  b. Must use concurrently with "1" of the following for migraine prophylaxis: amitriptyline, atenolol, divalproex, metoprolol, propranolol, topiramate, valproate or venlafaxine  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
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<tr>
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<th>Covered Uses</th>
<th>Criteria</th>
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<tbody>
<tr>
<td></td>
<td>sumatriptan,</td>
<td>Migraine headache</td>
<td>Exclusion Criteria: N/A</td>
</tr>
<tr>
<td></td>
<td>naproxen</td>
<td></td>
<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<tr>
<td></td>
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<td></td>
<td>a. Failure or clinically significant adverse effects to ALL of the alternatives: naproxen AND sumatriptan</td>
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<td></td>
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<td></td>
<td>b. Failure or clinically significant adverse effects to &quot;1&quot; of the following: rizatriptan or rizatriptan ODT</td>
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<td><strong>Age Restrictions:</strong> Must be age of 18 years or older</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Sutent</td>
<td>sunitinib</td>
<td></td>
<td><strong>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</strong></td>
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<tr>
<td>Belsomra</td>
<td>suvorexant</td>
<td>Insomnia</td>
<td>Exclusion Criteria: N/A</td>
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<td><strong>Required Medical Information:</strong> Must meet all of the following requirements:</td>
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<td></td>
<td>a. Failure or clinically significant adverse effects to the following: zolpidem</td>
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<td>b. Failure or clinically significant adverse effects to &quot;1&quot; of the following: eszopiclone or zaleplon</td>
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<td><strong>Age Restrictions:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> N/A</td>
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<tr>
<td>Astagraf XL</td>
<td>tacrolimus ER</td>
<td>Prophylaxis of organ rejection in transplant (e.g. Graft-Versus-Host Disease or GVHD)</td>
<td>Exclusion Criteria: N/A</td>
</tr>
<tr>
<td>capsule</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td></td>
<td>a. Confirmed diagnosis</td>
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<td><strong>Age Restriction:</strong> N/A</td>
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<td><strong>Prescriber Restrictions:</strong> Transplant specialist</td>
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<tr>
<td>Envarsus XR</td>
<td>tacrolimus ER</td>
<td>Prophylaxis of organ rejection in transplant (e.g. Graft-Versus-Host Disease or GVHD)</td>
<td>Exclusion Criteria: N/A</td>
</tr>
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<td>tablet</td>
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<td><strong>Required Medical Information:</strong> Must meet the following requirement:</td>
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<td></td>
<td>a. Confirmed diagnosis</td>
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<td></td>
<td><strong>Age Restriction:</strong> N/A</td>
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<tr>
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<td></td>
<td></td>
<td><strong>Prescriber Restrictions:</strong> Transplant specialist</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
<td>Covered Uses</td>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>tacrolimus</td>
<td>topical ointment</td>
<td><strong>Atopic dermatitis (i.e. eczema)</strong></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the alternatives: betamethasone dipropionate 0.05% (lotion, ointment, cream), betamethasone valerate 0.1% (ointment, cream), clobetasol 0.05% (ointment, cream, foam, gel, solution), clobetasol-emollient 0.05 % topical cream, fluocinolone 0.025% (cream, ointment), fluocinonide 0.05% (cream, ointment, solution), Fluocinonide-E 0.05 % topical cream, mometasone 0.1% (ointment, cream, solution), triamcinolone 0.1% (cream, ointment, lotion), OR triamcinolone 0.5% (ointment, cream)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Atopic dermatitis affecting the eyelids or genital areas</strong></td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>a. Confirmed diagnosis</td>
<td></td>
</tr>
<tr>
<td>tadalafil</td>
<td></td>
<td><strong>Erectile dysfunction (ED)</strong></td>
<td>Not a covered benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Failure or clinically significant adverse effects to &quot;2&quot; of the following: doxazosin, finasteride, tamsulosin or terazosin</td>
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<td><strong>Benign prostatic hyperplasia (BPH)</strong></td>
<td>N/A</td>
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<td>a. Documented WHO Functional Class II or above.</td>
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<td>b. Failure or clinically significant adverse effect to sildenafil.</td>
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<td><strong>Open-angle glaucoma or ocular hypertension</strong></td>
<td>N/A</td>
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<tr>
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<td></td>
<td>a. Failure or clinically significant adverse effects to the following: latanoprost</td>
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<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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</tbody>
</table>
|         |               | **Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|         |               |                                                                         |
| Nucynta ER | tapentadol   | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria |
| Nucynta IR | tapentadol   | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria |
| tazarotene cream |             | **Covered Uses:** Acne vulgaris (acne)  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to "1" of the following: tretinoin cream OR tretinoin gel  
  b. Failure or clinically significant adverse effects to "2" of the following: benzoyl peroxide topical, clindamycin topical or erythromycin topical  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** Dermatologist |
| temozolomide |             | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Aubagio | teriflunomide | **Covered Uses:** Relapsing form of multiple sclerosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Documentation of liver transaminase and bilirubin levels;  
  b. If female, confirmation of negative pregnancy test at initiation of therapy and use of contraceptive throughout treatment duration;  
  c. Failure or clinically significant adverse effects to "1" of the following: glatiramer or Glatopa; as evidenced by at least "1" of the following:  
    1. Member continues to have clinical relapses (at least one relapse within the past 12 months);  
    2. Member continues to have CNS lesion progression as shown in MRI;  
    3. Member continues to have worsening disability (e.g. decreased mobility, decreased ability to perform daily activities, increase in EDSS score, etc.). |
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<th>Brand</th>
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<th>Criteria</th>
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| Forteo | teriparatide | **Age Restrictions:** N/A  
**Prescriber Restrictions:** Neurologist  
**Covered Uses:** Osteoporosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Documentation of a T-score less than -2.5 at the lumbar spine, hip (total hip or femoral neck), or radius (one-third radius site).  
b. Documented inadequate response (e.g. greater than 3 percent decrease in bone mineral density from baseline, fracture from minimal trauma) while receiving the following, or clinically significant adverse effects to all of the following:  
i. An oral bisphosphonate (e.g. alendronate)  
ii. An intravenous bisphosphonate (e.g. zoledronic acid)  
iii. Prolia  
iv. Tymlos  
c. Patient is concurrently receiving calcium and vitamin D supplement.  
d. The combined duration of treatment with any parathyroid hormone analogs has not exceeded a lifetime maximum of 24 months (i.e. abaloparatide and teriparatide)  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Egrifta | tesamorelin | **Covered Uses:** Reduction of excess abdominal fat in HIV-infected patients with lipodystrophy  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. BMI greater than 20 kg/m²  
b. Waist circumference greater than or equal to 95 cm in men and greater than or equal to 94 cm in women  
c. Waist-to-hip ratio greater than or equal to 0.94 for males and greater than or equal to 0.88 for females  
d. Fasting blood glucose less than 150mg/dL  
e. No history of type 1 diabetes or type 2 diabetes  
f. Documentation of concurrent antiretroviral therapy  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
| testosterone topical gel/pump 1% | Please refer to Testosterone Drug Class Prior Authorization Criteria |
| tetrabenazine | **Covered Uses:** Treatment of chorea associated with Huntington’s disease  
**Exclusion Criteria:** Check CCS eligibility  
**Required Medical Information:** Must meet the following requirement:  
a. Confirmed diagnosis |
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</table>
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** Neurologist |
|       |         | **Covered Uses:** Seizure  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet all of the following requirements:  
|       | tiagabine | a. Failure or clinically significant adverse effects to TWO of the alternatives: carbamazepine, divalproex, ethosuximide, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate OR zonisamide  
|       |         | b. Must use concurrently with at least ONE other anticonvulsant medication  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** Neurologist |
| Brilinta 60mg | ticagrelor | **Covered Uses:** Must meet "1" of the following:  
|       |         | a. Acute Coronary Syndrome (ACS): unstable angina, Non-ST Elevation Myocardial Infarction (NSTEMI), ST-segment Elevation Myocardial Infarction (STEMI)  
|       |         | b. History of myocardial infarction  
|       |         | c. Percutaneous coronary intervention  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet the following requirement:  
|       |         | a. Maintenance dose of aspirin should not exceed 100 mg per day  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** N/A |
| Brilinta 90mg | ticagrelor | **Covered Uses:** Must meet "1" of the following:  
|       |         | a. Acute Coronary Syndrome (ACS): unstable angina, Non-ST Elevation Myocardial Infarction (NSTEMI), ST-segment Elevation Myocardial Infarction (STEMI)  
|       |         | b. History of myocardial infarction  
|       |         | c. Percutaneous coronary intervention  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet the following requirement:  
|       |         | a. Maintenance dose of aspirin should not exceed 100 mg per day  
|       |         | **Age Restrictions:** N/A  
|       |         | **Prescriber Restrictions:** N/A |
| Betimol | timolol | **Covered Uses:** Open-angle glaucoma or ocular hypertension  
|       |         | **Exclusion Criteria:** N/A  
|       |         | **Required Medical Information:** Must meet the following requirement:  
|       |         | a. Failure or clinically significant adverse effects to “2” of the following: levobunolol, metipranolol or timolol  
|       |         | **Age Restrictions:** N/A  
<p>|       |         | <strong>Prescriber Restrictions:</strong> N/A |</p>
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<tr>
<th>Brand</th>
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<th>Covered Uses</th>
<th>Criteria</th>
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</table>
| **Spiriva Respimat 1.25 mcg** | tiotropium 1.25 mcg            | Covered Uses: Asthma               | **Required Medical Information:** Must meet the following requirement: a. Failure or clinically significant adverse effects to “2” of the following for “2” consecutive months each: Asmanex Twisthaler, Flovent, Pulmicort or QVAR  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| **Spiriva HandiHaler**     | tiotropium 18 mcg              | Covered Uses: Chronic Obstructive Pulmonary Disease (COPD)  
Exclusion Criteria: N/A  
**Required Medical Information:** Must meet the following requirement: a. Failure or clinically significant adverse effects to “1” formulary long acting bronchodilator: Incruse Ellipta, Stiolto Respimat, Tudorza or Serevent  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| **Spiriva Respimat 2.5 mcg** | tiotropium 2.5 mcg            | Covered Uses: Chronic Obstructive Pulmonary Disease (COPD)  
Exclusion Criteria: N/A  
**Required Medical Information:** Must meet the following requirement: a. Failure or clinically significant adverse effects to “1” formulary long acting bronchodilator: Incruse Ellipta, Stiolto Respimat, Tudorza or Serevent  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| **Zylet**                  | tobramycin 0.3%, loteprednol    | Covered Uses: Bacterial conjunctivitis  
Exclusion Criteria: N/A  
**Required Medical Information:** Must meet "1" of the following requirements: a. Failure or clinically significant adverse effects to "2" of the following: ciprofloxacin 0.3% drops, ciprofloxacin 0.3% ointment, erythromycin ointment, gentamicin drops, gentamicin ointment, levofloxacin 0.5% drops, neomycin/polymyxin b/dexamethasone drops, neomycin/polymyxin b/dexamethasone ointment, neomycin/polymyxin b/hydrocortisone eye drops, ofloxacin 0.3% drops, sulfacetamide 10% drops, sulfacetamide 10% ointment, sulfacetamide/prednisolone drops, tobramycin drops, tobramycin ointment, tobramycin/dexamethasone drops, tobramycin/dexamethasone ointment or Vigamox 0.5% drops  
b. Prescribed by a specialist (e.g. Infectious Disease specialist, Ophthalmologist, Optometrist)  
Age Restrictions: N/A  
Prescriber Restrictions: See Required Medical Information |
|                           | tobramycin solution ampoule for nebulization | Covered Uses: Cystic Fibrosis  
Exclusion Criteria: N/A  
**Required Medical Information:** Must meet the following requirement: a. Confirmed diagnosis |
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<th>Criteria</th>
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</table>
| Actemra     | toclizumab            | Age Restrictions: N/A  
Prescriber Restrictions: Infectious Disease specialist, Pulmonologist |
| Xeljanz     | tofacitinib           | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria |
| Tolcapone   |                       | Covered Uses: Parkinson’s disease  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
a. Must use concurrently with carbidopa and levodopa; AND  
b. Failure or clinically significant adverse effects to formulary entacapone  
Age Restrictions: N/A  
Prescriber Restrictions: Neurologist |
| Trokendi XR | topiramate            | Covered Uses: Seizures or migraine prophylaxis  
Exclusion Criteria: Check CCS eligibility  
Required Medical Information: Must meet the following requirement:  
a. Medical justification why formulary topiramate cannot be used  
Age Restrictions: N/A  
Prescriber Restrictions: Neurologist |
| Yondelis    | trabectedin           | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| ConZip      | tramadol biphasic IR/ER capsule | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria |
|             | tramadol ER           | Please refer to Opioid Analgesic Drug Class Prior Authorization Criteria |
| Mekinist    | trametinib            | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| Tranexamic acid tablet |                       | Covered Uses: Cyclic heavy menstrual bleeding  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: OB-GYN specialist |
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Herceptin</td>
<td>trastuzumab</td>
<td><strong>Covered Uses:</strong> Open-angle glaucoma or ocular hypertension&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet the following requirement:&lt;br&gt; a. Failure or clinically significant adverse effects to the following: latanoprost&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> N/A</td>
</tr>
<tr>
<td>Travatan Z</td>
<td>travoprost</td>
<td><strong>Covered Uses:</strong> Pulmonary Arterial Hypertension&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet all of the following requirements:&lt;br&gt; a. Documented WHO Functional Class II or above&lt;br&gt; b. Failure or clinically significant adverse effect to sildenafil&lt;br&gt; c. Failure or clinically significant adverse effect to Letairis, Opsumit or Tracleer&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
</tr>
<tr>
<td>Orenitram</td>
<td>treprostinil ER</td>
<td><strong>Covered Uses:</strong> Pulmonary Arterial Hypertension&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet all of the following requirements:&lt;br&gt; a. Documented WHO Functional Class II or above&lt;br&gt; b. Failure or clinically significant adverse effect to sildenafil&lt;br&gt; c. Failure or clinically significant adverse effect to Letairis, Opsumit or Tracleer&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
</tr>
<tr>
<td>Tyvaso</td>
<td>treprostinil nebulizing solution</td>
<td><strong>Covered Uses:</strong> Pulmonary Arterial Hypertension&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet all of the following requirements:&lt;br&gt; a. Member is not a candidate for parenteral prostanoid therapy&lt;br&gt; b. Must meet “1” of the following:&lt;br&gt; i. Documented WHO Functional Class IV&lt;br&gt; ii. Documented WHO Functional Class III and “1” of the following:&lt;br&gt; • Evidence of rapid disease progression&lt;br&gt; • Markers for poor clinical prognosis&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
</tr>
<tr>
<td>Remodulin</td>
<td>treprostinil vial</td>
<td><strong>Covered Uses:</strong> Pulmonary Arterial Hypertension&lt;br&gt;<strong>Exclusion Criteria:</strong> N/A&lt;br&gt;<strong>Required Medical Information:</strong> Must meet “1” of the following requirements:&lt;br&gt; a. Documented WHO Functional Class IV&lt;br&gt; b. Documented WHO Functional Class III and “1” of the following:&lt;br&gt; i. Evidence of rapid disease progression&lt;br&gt; ii. Markers for poor clinical prognosis&lt;br&gt;<strong>Age Restrictions:</strong> N/A&lt;br&gt;<strong>Prescriber Restrictions:</strong> Cardiologist, Pulmonologist</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Covered Uses: Wilson's disease</td>
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<tr>
<td>Lonsurf</td>
<td>trifluridine, tipiracil</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
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<tr>
<td>Trelstar</td>
<td>triptorelin pamoate inj</td>
<td>Covered Uses: Prostate Cancer</td>
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<td>trospium or trospium ER</td>
<td>Covered Uses: Overactive bladder (OAB)</td>
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<tr>
<td>Anoro Ellipta</td>
<td>umeclidinium, vilanterol</td>
<td>Covered Uses: COPD</td>
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<td>Brand</td>
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<td>Criteria</td>
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| **unfractionated heparin** | Covered Uses: Must meet “1” of the following:  
  a. Prophylaxis of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)  
  b. Maintenance of line patency (line flushing)  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
  a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: N/A |
| **Stelara** | ustekinumab | Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria |
| **Ingrezza** | valbenazine | Covered Uses: Tardive Dyskinesia  
Exclusion Criteria: N/A  
Required Medical Information: Must meet all of the following requirements:  
  a. Documentation of functional impairment  
  b. Documentation of “1” of the following requirements:  
    i. Switching from a first-generation neuroleptic to a second-generation neuroleptic  
    ii. Discontinuation or dose modification of the offending medication  
Age Restrictions: Age of 18 years or older  
Prescriber Restrictions: Neurologist, Psychiatrist |
| **valganciclovir** | Covered Uses: Must meet “1” of the following:  
  a. CMV retinitis  
  b. CMV infection prophylaxis  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
  a. Confirmed diagnosis  
Age Restrictions: N/A  
Prescriber Restrictions: HIV specialist, Infectious Disease specialist, Transplant specialist |
| **vancomycin IV** | Please refer to the Intravenous Antibiotics Drug Class Prior Authorization Criteria |
| **Caprelsa** | vandetanib | Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria |
| **Varizig** | varicella-zoster immune globulin | Covered Uses: Post-exposure prophylaxis of varicella in high risk individuals  
Exclusion Criteria: N/A  
Required Medical Information: Must meet the following requirement:  
  a. Documentation of one of the following: immunocompromised children and adults, newborns of mothers with varicella shortly before or after delivery, premature infants, neonates and infants less than one year of age, adults without evidence of immunity OR pregnant women  
Age Restrictions: N/A |
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<tr>
<th>Brand</th>
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<tr>
<td>Entyvio</td>
<td>vedolizumab</td>
<td>Prescriber Restrictions: N/A. Please refer to Rheumatic and Inflammatory Diseases Drug Class Prior Authorization Criteria.</td>
</tr>
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<td>velpatasvir, sofosbuvir</td>
<td>Please refer to the Hepatitis C Drug Class Criteria.</td>
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<tr>
<td>Zelboraf</td>
<td>vemurafenib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria.</td>
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<tr>
<td>Venclexta</td>
<td>venetoclax</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria.</td>
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<tr>
<td>Viibryd</td>
<td>vilazodone</td>
<td>Covered Uses: Major Depressive Disorder. Exclusion Criteria: N/A. Required Medical Information: Must meet the following requirement: a. Failure or clinically significant adverse effects to at least a 6-week treatment course of &quot;2&quot; of the following: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER, bupropion OR mirtazapine. Age Restrictions: N/A. Prescriber Restrictions: Psychiatrist (new start).</td>
</tr>
<tr>
<td>Marqibo</td>
<td>vincristine liposomal</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria.</td>
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<tr>
<td>Brand</td>
<td>Generic</td>
<td>Criteria</td>
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<tr>
<td>Erivedge</td>
<td>vismodegib</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
|         | **voriconazole oral** | **Covered Uses**: Must meet “1” of the following:  
a. Invasive aspergillosis: treatment or prophylaxis  
b. Pulmonary aspergillosis, chronic  
c. Fungal infection caused by Scedosporium apiospermum, Scedosporium prolificans or Fusarium species  
d. Infection prophylaxis in graft-versus-host disease  
e. Infection prophylaxis in allogeneic hematopoietic stem cell transplant (HSCT) or certain autologous HSCT  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Confirmed diagnosis  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A |
| Trintellix | vortioxetine | **Covered Uses**: Major Depressive Disorder  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to at least a 6-week treatment course of "2" of the following: citalopram, escitalopram, fluoxetine, paroxetine, sertraline, duloxetine DR, venlafaxine, venlafaxine ER, bupropion OR mirtazapine  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: Psychiatrist (new start) |
|          | zaleplon      | **Covered Uses**: Insomnia  
**Exclusion Criteria**: N/A  
**Required Medical Information**: Must meet the following requirement:  
a. Failure or clinically significant adverse effects to the alternative: zolpidem  
**Age Restrictions**: N/A  
**Prescriber Restrictions**: N/A  
**Coverage Duration**: |
<table>
<thead>
<tr>
<th>Brand</th>
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</thead>
<tbody>
<tr>
<td>Zaltrap</td>
<td>ziv-aflibercept</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td></td>
<td>zaleplonzine sodium</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
<tr>
<td></td>
<td>zoledronic acid IV</td>
<td>Please refer to Antineoplastic Agents Drug Class Prior Authorization Criteria</td>
</tr>
</tbody>
</table>
| Zomig Nasal Spray | zolmitriptan solution                      | **Covered Uses:** Osteoporosis  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet “1” of the following requirements:  
  a. Documentation of all of the following:  
    i. Documentation of a T-score less than -2.5 at the spine or hip.  
    ii. Documentation of “1” of the following:  
       1. Documented inadequate response to oral bisphosphonate within the past 6 months (180 days) (e.g. greater than 3 percent decrease in bone mineral density from baseline, or osteoporotic fracture while taking an oral bisphosphonate, etc.).  
       2. Patient is not a candidate for oral bisphosphonate (e.g. co-morbid GI condition, intolerance to an oral bisphosphonate, etc.).  
  b. Severe osteoporosis documented with “1” of the followings:  
    i. T-score less than -3.5 at the spine or hip  
    ii. Documentation or history of osteoporotic fractures.  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
|             | zolmitriptan orally-disintegrating           | **Covered Uses:** Migraine headache  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
  a. Failure or clinically significant adverse effects to the alternative: zolmitriptan orally-disintegrating  
  b. Failure or clinically significant adverse effects to the alternative: sumatriptan  
  c. Failure or clinically significant adverse effects to "1" of the following: rizatriptan or rizatriptan ODT  
**Age Restrictions:** Must be age of 18 years or older  
**Prescriber Restrictions:** N/A |
|             | zolmitriptan tablet, zolmitriptan orally-disintegrating | **Covered Uses:** Migraine headache  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet the following requirement:  
  a. Failure or clinically significant adverse effects to "1" of the following: rizatriptan or rizatriptan ODT  
**Age Restrictions:** Must be age of 12 to 17 years  
**Prescriber Restrictions:** N/A |
<table>
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<tr>
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</thead>
</table>
| ZolpiMist | zolpidem | **Covered Uses:** Insomnia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the alternative: zolpidem  
b. Failure or clinically significant adverse effects to "1" of the alternatives: eszopiclone or zaleplon  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Zolpidem 1.75mg and 3.5mg sublingual tablets | zolpidem | **Covered Uses:** Insomnia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the alternative: zolpidem  
b. Failure or clinically significant adverse effects to "1" of the alternatives: eszopiclone or zaleplon  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Edluar | zolpidem 5mg and 10mg sublingual tablets | **Covered Uses:** Insomnia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the alternative: zolpidem  
b. Failure or clinically significant adverse effects to "1" of the alternatives: eszopiclone OR zaleplon  
c. Females only: Failure or clinically significant adverse effects to the alternative: zolpidem 5mg for initiation only  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Zolpidem ER | zolpidem | **Covered Uses:** Insomnia  
**Exclusion Criteria:** N/A  
**Required Medical Information:** Must meet all of the following requirements:  
a. Failure or clinically significant adverse effects to the following: zolpidem immediate release  
b. Failure or clinically significant adverse effects to "1" of the following: eszopiclone or zaleplon  
**Age Restrictions:** N/A  
**Prescriber Restrictions:** N/A |
| Nebulizer | | Please refer to Pharmacy Policy Nebulizer |
