Central California Alliance for Health

Pharmacy Prior Authorization Criteria

June 2025

Nondiscrimination Notice

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

The Alliance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact the Alliance between 8 AM – 5:30 PM, Monday through Friday, by calling **800-700-3874**. If you cannot hear or speak well, please call **800-735-2929** (**TTY**: Dial 711). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Central California Alliance for Health
1600 Green Hills Rd, Suite 101
Scotts Valley, CA 95066
800-700-3874
800-735-2929 (**TTY**: Dial 711)

HOW TO FILE A GRIEVANCE

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact the Alliance's Senior Grievance Specialist between 8 AM and 5:30 PM, Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (**TTY**: Dial 711).

- In writing: Fill out a complaint form or write a letter and send it to:

  Central California Alliance for Health
  Attn: Senior Grievance Specialist
  1600 Green Hills Rd, Suite 101
  Scotts Valley, CA 95066

- In person: Visit your doctor's office or the Alliance and say you want to file a grievance.

- Electronically: Visit the Alliance's website at www.thealliance.health.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

<u>OFFICE OF CIVIL RIGHTS</u> – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- <u>By phone</u>: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- <u>In writing</u>: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- <u>Electronically</u>: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Taglines

English Tagline

ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)

请注意：**如果您需要以您的母**语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929)。**我**们另外还提供针对残疾人士的帮助和服务，**例如盲文和大字体**阅读，**提供您方便取用**。请致电 1-800-700-3874 (TTY: 1-800-735-2929)。这些服务都**是免**费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での**対応**が**必要**な**場合**は 1-800-700-3874 (TTY: 1-800-735-2929)へお**電話**ください。**点字**の**資料**や**文字**の**拡大表示**など、**障**がいをお**持**ちの**方**のためのサービスも**用意**しています。 1-800-700-3874 (TTY: 1-800-735-2929)へお**電話**ください。これらのサービスは**無料**で**提供**しています。

한국어 태그라인 **(Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ"ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ"1-800-700-3874 (TTY: 1-800-735-2929). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ" ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່"ໃຫ້ໂທຫາເບີ" 1-800-700-3874 (TTY: 1-800-735-2929)ບໍ່ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ0

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

Taglines

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

Forward

Central California Alliance for Health (The Alliance), with direction from the Pharmacy & Therapeutics (P&T) Committee, has developed this prior authorization (PA) criteria document to be used by Alliance providers for Physician-Administered Drugs billed as medical claims. Effective January 1, 2022, this prior authorization criteria document does not apply to pharmacy services billed as pharmacy claims.

Some Physician/Facility-Administered Drugs (PADs) billed as a medical claim may require prior authorization. Prior authorization (PA) criteria are based on the recommendations of the P&T Committee. Providers can use the Procedure Code Lookup Tool available on the Alliance Provider Portal to find information on PA requirement, age, service, frequency and diagnosis code limits/requirements upon claim submission.

If a Physician-Administered Drug (PAD) requiring prior authorization has no PA criteria listed in this document, it will be reviewed for medical necessity based upon Alliance policies as well as nationally recognized standards. For more information on the authorization review process for PADs, please see Policy 403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization.

The Alliance will prefer the use of a Biosimilar over its branded biologic counterpart. For more information, please see Policy 403-1142 - Biosimilars.

For providers who wish to administer Synagis in their office, the Synagis Statement of Medical Necessity Form is required to be submitted along with the prior authorization request. The Alliance will cover Synagis for members who meet Conditions of Usage listed in Policy 403-1120 – Synagis.

Medi-Cal Carved-Out Drugs

For Medi-Cal members, the Alliance does not cover drugs used for treatment of HIV/AIDS/Hepatitis B, alcohol and heroin detoxification and dependency, clotting factor disorder, and antipsychotic drugs listed on pages 5-9 of the MCP: County Organized Health System file. These carved-out or non-capitated drugs should be billed to Fee-For-Service (FFS) Medi-Cal. Procedures for Fee-For-Service reimbursement for carved-out drugs can be found on the Medi-Cal website in the Part 2 manual for Pharmacy.

Submitting Authorization Requests for Physician-Administered Drugs

Authorization requests for Physician-Administered Drugs billed as a medical claim may be submitted to the Alliance via the methods listed below. Submission of PA requests is preferred through the Alliance Provider Portal. If faxed or mailed, prior authorization requests must be submitted on the Prescription Drug Prior Authorization Request Form or Treatment Authorization Request (TAR) Form for all Alliance members. The forms can be found on the Pharmacy page on the Alliance provider website or Form Library.

- The Alliance Provider Portal (preferred)
- Fax (831) 430-5851
- United States (US) Mail
  Central California Alliance for Health
  Health Services Department – Pharmacy
  PO Box 660012
  Scotts Valley, CA 95067-0012

Questions regarding urgent prior authorization requests may be directed to the Alliance Pharmacy department by calling (831) 430-5507 or (800) 700-3874 ext. 5507.

To complete a prior authorization request, *all* of the following information must be provided:

- Member name, ID number and DOB.
- Requesting provider name and contact information.
- Description of requested drug or item (must include Healthcare Common Procedure Coding System (HCPCS) code if physician or facility administered drug is requested).
- Prescriber name, NPI, address, phone number and fax number.
- Servicing provider name, NPI, address, phone number and fax number (if different).
- Diagnosis (or ICD code) that most accurately describes the indication for the medication. Please include all medically relevant diagnoses for review purposes.
- Quantity requested per fill or per date of service (DOS) (in “quantity” field).
- Number of fills or DOS requested (in “units” field).
- Directions for use.

- Expected duration of therapy.
- Documentation of appropriate clinical information that supports the medical necessity of the requested drug or item, including:
    - Other drugs or therapies for this indication that have already been tried and failed. Please include what the outcomes were.
    - Why preferred alternatives cannot be used.
    - Any additional information to support diagnosis and medical justification such as lab results and specialist consults.

Incomplete and/or illegible forms may be denied or voided.
Providers can contact the Alliance Pharmacy department at (800) 700-3874 ext. 5507.

For more information on the authorization review process, please see Policy 403-1103 - Pharmacy Authorization Request Review Process.

Carved-Out Drugs

The following drugs are carved out from the Alliance pharmacy benefit for Blood and Coagulation Factors. They are to be billed to State Medi-Cal, not the Alliance. Some of the medications may require a TREATMENT AUTHORIZATION REQUEST (TAR) submitted to State Medi-Cal prior to dispensing. For more information, please refer to above section on "Medi-Cal Carved-Out Drugs."

For Alliance Care IHSS members, all of these drugs require a Prior Authorization to be submitted to the Alliance.

Alcohol and Heroin Detoxification and Dependency Treatment Drugs
Acamprosate Calcium
Buprenorphine extended release injection
Buprenorphine HCl
Buprenorphine/Naloxone HCl
Buprenorphine implant (Probuphine)
Buprenorphine transdermal patch
Disulfiram
Lofexidine HCl
Naloxone HCl (oral and injectable)
Naltrexone (oral and injectable)
Naltrexone Microsphere injectable suspension

Antiviral Drugs
Abacavir/Lamivudine
Abacavir Sulfate
Abacavir Sulfate/Dolutegravir/Lamivudine (Triumeq)
Atazanavir/Cobicistat (Evotaz)
Atazanavir Sulfate
Bictegravir/Emtricitabine/Tenofovir Alafenamide
Cabotegravir (Apretude)
Cobicistat (Tybost)
Darunavir/Cobicistat (Prezcobix)
Darunavir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (Symtuza)
Darunavir Ethanolate

Delavirdine Mesylate
Dolutegravir/Lamivudine (Dovato)
Dolutegravir (Tivicay)
Dolutegravir/Rilpivirine
Doravirine
Doravirine/Lamivudine/Tenofovir Disoproxil Fumarate (Delstrigo)
Efavirenz
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate
Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate (Symfi)
Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate (Symfi Lo)
Elvitegravir (Vitekta)
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (Genvoya)
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Disoproxil Fumarate (Stribild)
Emtricitabine
Emtricitabine/Rilpivirine/Tenofovir Alafenamide (Odefsey)
Emtricitabine/Rilpivirine/Tenofovir Disoproxil Fumarate
Emtricitabine/Tenofovir Alafenamide
Enfuvirtide
Etravirine
Fosamprenavir Calcium
Fostemsavir Tromethamine
Ibalizumab-uiyk
Indinavir Sulfate
Lamivudine
Lamivudine and Tenofovir Disoproxil Fumarate (Cimduo)
Lopinavir/Ritonavir
Maraviroc
Nelfinavir Mesylate
Nevirapine
Raltegravir Potassium
Rilpivirine Hydrochloride
Ritonavir
Saquinavir
Saquinavir Mesylate

Stavudine
Tenofovir Alafenamide Fumarate
Tenofovir Disoproxil/Emtricitabine
Tenofovir Disoproxil Fumarate
Tipranavir
Zidovudine/Lamivudine
Zidovudine/Lamivudine/Abacavir Sulfate

Blood Factors: Clotting Factor Disorder Treatments
Antihemophilic factor VIII/von Willebrand factor complex (human)
Anti-inhibitor
Coagulation factor X (human)
Emicizumab-kxwh (Hemlibra)
Factor VIIa (antihemophilic factor, recombinant)
Factor VIII (antihemophilic factor, human)
Factor VIII (antihemophilic factor, recombinant)
Factor VIII (antihemophilic factor, recombinant) (Afstyla), per IU
Factor VIII (antihemophilic factor, recombinant) (Novoeight)
Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per IU
Factor VIII (antihemophilic factor, recombinant) PEGylated, per IU
Factor IX (antihemophilic factor, purified, nonrecombinant)
Factor IX (antihemophilic factor, recombinant)
Factor IX (antihemophilic factor, recombinant) (Rixubis)
Factor IX, albumin fusion protein, (recombinant), (Idelvion) per IU
Factor IX complex
Factor X (human), per IU
Factor XIII (antihemophilic factor, human)
Factor XIII A-Subunit (recombinant)
Hemophilia clotting factor, not otherwise classified
Injection, factor VIII (antihemophilic factor, recombinant) (Obizur)
Injection, factor VIII (antihemophilic factor, recombinant) pegylated-aucl (Jivi), 1 IU
Injection, factor VIII, fc fusion protein (recombinant)
Injection Factor IX, (antihemophilic factor, recombinant), glycopegylated, (Rebinyn), 1 IU
Injection, factor IX fusion protein (recombinant)
Von Willebrand factor (recombinant) (Vonvendi), per IU

Von Willebrand factor complex (human), Wilate
Von Willebrand factor complex (Humate-P)

Psychiatric Drugs
Amantadine HCl
Aripiprazole
Aripiprazole Lauroxil
Asenapine (Saphris)
Asenapine Transdermal System
Benztropine Mesylate
Brexpiprazole (Rexulti)
Cariprazine
Chlorpromazine HCl
Clozapine
Fluphenazine Decanoate
Fluphenazine HCl
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Iloperidone (Fanapt)
Isocarboxazid
Lithium Carbonate
Lithium Citrate
Loxapine Inhalation Powder
Loxapine Succinate
Lumateperone
Lurasidone Hydrochloride
Molindone HCl
Olanzapine
Olanzapine/Samidorphan
Olanzapine Fluoxetine HCl
Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Paliperidone (oral and injectable)

Perphenazine
Phenelzine Sulfate
Pimavanserin
Pimozide
Quetiapine
Risperidone
Risperidone Microspheres
Selegiline (transdermal only)
Thioridazine HCl
Thiothixene
Thiothixene HCl
Tranylcypromine Sulfate
Trifluoperazine HCl
Trihexyphenidyl
Ziprasidone
Ziprasidone Mesylate

Table of Contents

rituximab
(Rituxan, Ruxience [rituximab-pvvr], Truxima [rituximab-abbs])

Neoplastic Disease (November 2020)

CRITERIA

- Rheumatoid arthritis diagnosis and:
    - Has been evaluated by a rheumatologist and
    - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or has severe active rheumatoid arthritis and
    - Rituxan requires medical justification as to why a biosimilar agent cannot be used. Examples of biosimilar:
        - Ruxience (rituximab-pvvr)*
        - Truxima (rituximab-abbs)*

*Prior authorization required

- All other diagnoses:
    - Requested regimen and dose are per NCCN or MCG guidelines and
    - Rituxan requires medical justification as to why a biosimilar agent cannot be used. Examples of biosimilar:
        - Ruxience (rituximab-pvvr)*
        - Truxima (rituximab-abbs)*

*Prior authorization required

QUANTITY LIMITS
Rheumatoid arthritis:
IV: 1000mg on days 1 and 15
May retreat every 24 weeks

For all other diagnoses: See package insert

trastuzumab
(Herceptin, Ontruzant [trastuzumab-dttb], Herzuma [trastuzumab-pkrb], Trazimera [trastuzumab-qyyp], Ogivri [trastuzumab-dkst], Kanjinti [trastuzumab-anns])

Neoplastic Disease (November 2020)

CRITERIA

- Requested regimen and dose are per NCCN guidelines and Herceptin requires medical justification as to why a biosimilar agent cannot be used. Examples of biosimilar:
    - Ontruzant (trastuzumab-dttb)*
    - Herzuma (trastuzumab-pkrb)*
    - Trazimera (trastuzumab-qyyp)*
    - Ogivri (trastuzumab-dkst)*
    - Kanjinti (trastuzumab-anns)*

*Prior authorization required

bevacizumab
(Avastin, Zirabev [bevacizumab-bvzr], Mvasi [bevacizumab-awwb], Alymsys [bevacizumab-maly])

Neoplastic Disease (June 2024)

CRITERIA

- Diabetic macular edema diagnosis
- Macular edema following retinal vein occlusion diagnosis
- Neovascular age-related macular degeneration and no concurrent ocular or periocular infection diagnosis
- Non-proliferative diabetic retinopathy
- Proliferative diabetic retinopathy with and without macular edema
- All other diagnoses:
    - Requested regimen and dose are per NCCN guidelines and Avastin requires medical justification as to why a biosimilar agent cannot be used. Examples of biosimilars:
        - Zirabev (bevacizumab-bvzr)*
        - Mvasi (bevacizumab-awwb)*
        - Alymsys (bevacizumab-maly)*

*Prior authorization required

FDA-Approved Oncology Drugs

Neoplastic Disease (September 2024)

CRITERIA

- Diagnosis of cancer:
    - Prescribed by hematologist or oncologist and
    - Use FDA-approved indications and Medi-Cal guidelines and/or in regimens consistent with NCCN Guidelines

Examples of FDA-approved Oncology Drugs include:
abiraterone acetate, ado-trastuzumab emtansine, afatinib dimaleate, aldesleukin, amifostine (Ethyol), asparaginase (Erwinaze), bendamustine, bevacizumab, Bexarotene, bleomycin sulfate, bortezomib, bosutinib, busulfan, cabazitaxel, capecitabine, carboplatin, carfilzomib, carmustine (BiCNU), ceritinib, cetuximab, cisplatin, cladribine, crizotinib, cyclophosphamide, cytarabine, dabrafenib, mesylate, dacarbazine, dasatinib, daunorubicin HCL, denileukin diftitox, docetaxel, doxorubicin HCL, eflapegrastim-xnst (Rolvedon), enzalutamide, epirubicin HCL, eribulin mesylate, erlotinib HCL, estramustine phosphate sodium, etoposide, everolimus, exemestane, floxuridine, fulvestrant, gemcitabine HCL, goserelin acetate, hydroxyurea, idelalisib, ifosfamide, ifosfamide/ mesna, imatinib mesylate, Inotuzumab ozogamicin (Besponsa), ipilimumab, irinotecan HCL, ixabepilone, lapatinib, ditosylate, letrozole, leuprolide acetate, lomustine, mechlorethamine HCL, megestrol acetate, melphalan, mitomycin, mitotane, mitoxantrone HCL, nilotinib HCL, nivolumab, obinutuzumab, ofatumumab, olaparib, oxaliplatin, paclitaxel, paclitaxel nanoparticle albumin bound (nabpaclitaxel-Abraxane), palbociclib, panobinostat, panitumumab, pazopanib HCL, pegaspargase, pemetrexed disodium, pentostatin, pertuzumab, plicamycin, porfimer sodium, ramucirumab, regorafenib, rituximab, sorafenib tosylate, streptozocin, sunitinib malate, tamoxifen citrate, temozolomide, teniposide, thiotepa, topotecan HCL, trametinib dimethyl sulfoxide, trastuzumab, trastuzumab-hyaluronidase (Herceptin Hylecta), tretinoin, vandetanib, vinblastine sulfate, vismodegib, vorinostat, ziv-aflibercept

sirolimus protein-bound particles for injectable suspension (Fyarro)

Neoplastic Disease (September 2022)

CRITERIA

- Diagnosis of locally advanced unresectable or metastatic malignant Perivascular Epithelioid Cell Tumor (PEComa) and all of the following:
  - Prescribed by or in consultation with an oncologist
  - Patient is ≥ 18 years of age
  - Used as a single agent
  - Dose does not exceed 100 mg/m^2 IV on Days 1 and 8 of each 21-day cycle

RENEWAL CRITERIA

- Member has responded positively to the treatment as determined by the prescribing physician
- Member has not experienced unacceptable toxicity from the drug
- New dose does not exceed 100 mg/m^2 IV on Days 1 and 8 of each 21-day cycle
- Dose is at least 45 mg/m^2 IV on Days 1 and 8 of each 21-day cycle

QUANTITY LIMITS

100 mg/m2 administered on days one and eight of each 21-day cycle

palonosetron
(Aloxi)

Antiemesis/ Antivertigo (August 2019)

CRITERIA

- Prevention of nausea and vomiting due to moderately or highly emetogenic parenteral chemotherapy

QUANTITY LIMITS

Up to 0.25mg/5ml per cycle

reslizumab
(Cinqair)

Asthma and COPD (August 2019)

CRITERIA

- Diagnosis of severe asthma with an eosinophilic phenotype and meets all of the following criteria:
    - The patient is 18 years of age or older
    - The patient has a documented blood eosinophil level of at least 300 cells/mcL within the past 6 months
    - The patient is currently adherent to a maximally tolerated dose of an inhaled corticosteroid plus at least one other maintenance medication (e.g., a long-acting inhaled beta2-agonist, a long-acting muscarinic antagonist, leukotriene receptor antagonist, theophylline, or oral corticosteroid)
    - The patient has experienced at least 2 or more asthma exacerbations within the past 12 months (exacerbation is defined as an asthma-related event requiring hospitalization, emergency room visit, or systemic corticosteroid burst lasting at least 3 days)
    - Cinqair will be used as add-on maintenance treatment
    - The patient is not concurrently treated with Xolair, Dupixent, or another anti-IL-5 asthma biologic (e.g., Nucala, Fasenra)
    - Cinqair is prescribed by or given in consultation with a physician specializing in pulmonary medicine or allergy medicine

omalizumab
(Xolair)

Asthma and COPD (October 2018)

CRITERIA

- Diagnosis of moderate to severe persistent asthma in patients 6 years to 11 years and:
    - Positive skin test or in vitro reactivity to a perennial aeroallergen
    - Symptoms are inadequately controlled with max doses of inhaled corticosteroids
    - Pre-treatment serum IgE level between 30 and 1300 IU/ml

- Diagnosis of moderate to severe persistent asthma in patients 12 years and older and:
    - Positive skin test or in vitro reactivity to a perennial aeroallergen
    - Symptoms are inadequately controlled with max doses of inhaled corticosteroids
    - Pre-treatment serum IgE level between 30 and 700 IU/ml

- Diagnosis of chronic idiopathic urticaria (CIU) in patients 12 years and older and:
    - Must have the presence of urticaria (hives) on most days of the week, for a duration of longer than six (6) weeks and
    - Trial and failure of the following:
        - At least two (2) H1 antihistamines (loratadine, cetirizine, fexofenadine)
        - H1 antihistamine in combination with H2 (ranitidine, famotidine) or
        - H1 antihistamine in combination with Leukotriene modifier (Singulair)

crizanlizumab
(Adakveo)

Hematological Disorders (March 2020)

CRITERIA

- Trial and failure of hydroxyurea 500 mg capsule and the member is any of the following:
    - Adult with ≥ 3 moderate to severe pain crises per year
    - Adult who has sickle cell–associated pain or symptomatic chronic anemia that interferes with daily activities and quality of life
    - Adult with history of severe or recurrent acute chest syndrome (ACS)
    - Adults or child with SCD who has chronic kidney disease and is taking erythropoietin and
- Age ≥ 16 and
- Trial and failure of hydroxyurea, defined as experiencing a severe pain crisis (or vaso-occlusive crisis) while using the med, or experiencing other sickle-cell associated symptoms (such as sx of chronic anemia or acute chest syndrome) while using the med and
- Trial and failure of Endari*, defined as experiencing a severe pain crisis (or vaso-occlusive crisis) while using the med, or experiencing other sickle-cell associated symptoms (such as sx of chronic anemia or acute chest syndrome) while using the med

*Prior authorization required

QUANTITY LIMITS
Initial approval: x3 months

pegloticase 8mg/ml intravenous vial
(Krystexxa)

Gout and Related Diseases (October 2018)

CRITERIA

- Diagnosis of chronic gout with hyperuricemia and:
    - At least 3 gout flares in the previous 18 months that were inadequately controlled by colchicine or nonsteroidal anti-inflammatory drugs (NSAIDS) or oral or injectable corticosteroids

- Diagnosis of at least 1 gout tophus or has chronic gouty arthritis and:
    - Documentation of baseline serum uric acid level greater than 8 mg/dL and
    - Failure, contraindication or intolerance to previous therapy with maximum tolerated dose of two (2) xanthine oxidase inhibitors (allopurinol and febuxostat) and
    - Probenecid (alone or in combination with allopurinol or febuxostat)

treprostinil sodium
(Remodulin)

Cardiovascular Disease- Hypertension (November 2019)

CRITERIA

- Pulmonary Arterial Hypertension (PAH) with NYHA-WHO Functional Class III or greater and:
    - Has been evaluated by a cardiologist or pulmonologist and
    - Is being used in adjunct with or has inadequate response, intolerable side effect, or contraindication to both:
        - PDE-5 inhibitor such as sildenafil* or tadalafil* and
        - Endothelin receptor antagonist such as ambrisentan* (Letairis), macitentan* (Opsumit), bosentan* (Tracleer)

*Prior Authorization Required

epoprostenol
(Flolan)

Cardiovascular Disease- Hypertension (August 2016)

CRITERIA

- Pulmonary Arterial Hypertension (PAH) with NYHA-WHO Functional Class III or greater and:
    - Has been evaluated by a cardiologist or pulmonologist and
    - Is being used in adjunct with or has inadequate response, intolerable side effect, or contraindication to an ERA (ambrisentan, bosentan, or macitentan)*

*Prior Authorization Required

epoprostenol
(Veletri)

Cardiovascular Disease- Hypertension (August 2016)

CRITERIA

- Pulmonary Arterial Hypertension (PAH) with NYHA-WHO Functional Class III or greater and:
    - Has been evaluated by a cardiologist or pulmonologist and
    - Is being used in adjunct with or has inadequate response, intolerable side effect, or contraindication to an ERA (ambrisentan, bosentan, or macitentan)*

*Prior Authorization Required

inclisiran
(Leqvio)

Cardiovascular Disease-Lipid Irregularity (September 2022)

CRITERIA

- Patient has one of the following (diagnosis confirmed by requirements stated below):
    - Heterozygous familial hypercholesterolemia (HeFH) AND elevated LDL-C
    - Atherosclerotic cardiovascular disease (ASCVD) AND a serum LDL-C greater than or equal to 70 mg/dL at baseline
    - ASCVD-risk equivalent AND a serum LDL-C greater than or equal to 100 mg/dL at baseline

And

- Member must be 18 years of age or older
- Prescribed by or in consultation with a cardiologist, endocrinologist, a lipid specialist, or other specialist with expertise in treating heterozygous familial hypercholesterolemia (HeFH)
- Member is on high dose statin (atorvastatin 80 mg or rosuvastatin 40 mg) or a maximally tolerated dose with or without ezetimibe for at least 30 days. If patient is not on statin, documentation of intolerance to at least two different statins OR intolerance to only one statin with a documented history of rhabdomyolysis (as per AHA/ACC Guidelines: CK >10 x Upper Limit of Normal + renal injury) attributed to that statin must be submitted.
- Member must have tried and failed, is intolerant to or has a clinical contraindication to a PCSK9 inhibitor [such as Repatha (evolocumab) or Praluent (alirocumab)]
- Member will not take Leqvio concurrently with other PCSK9 inhibitor [such as Repatha (evolocumab) or Praluent (alirocumab)]

- Diagnosis of HeFH is confirmed by at least one of the following:
    - Genetic testing showing mutations of pathogenic variants of the low-density lipoprotein receptor (LDL-R) gene, or pathogenic variants of the apolipoprotein (ApoB) gene, mutations in proprotein convertase subtilisin/kexin type 9 (PCSK9), or homozygous mutations in the LDL-R adaptor protein-1
    - A first-degree relative with familial hypercholesterolemia, elevated cholesterol or early heart disease that may indicate familial hypercholesterolemia
    - A low-density lipoprotein-cholesterol (LDL-C) level of equal to or greater than 190 mg/dL, or lower with strong family histories and/or

physical findings such as xanthomas, xanthelasmas (cholesterol deposits in the eyelids or skin), or corneal arcus
    - A Dutch Lipid Clinic Network Criteria score of six or more
    - A diagnosis of a "definite" or "probable" FH per the Simon Broome FH diagnostic criteria

- Diagnosis of ASCVD (coronary heart disease [CHD], cardiovascular disease [CVD], or peripheral arterial disease [PAD]) as confirmed by at least one of the following:
    - Angina (stable or unstable)
    - Prior myocardial infarction or acute coronary syndrome
    - History of stroke or transient ischemic attack
    - Peripheral artery disease
    - Coronary or other arterial revascularization

- ASCVD risk equivalent as confirmed by at least one of the following:
    - Diabetes mellitus (DM)
    - Heterozygous familial hypercholesterolemia
    - 10-year ASCVD risk greater than or equal to 20%

RENEWAL CRITERIA

- Patient continues to meet initial coverage criteria
- Positive clinical response as evidenced by reduction of LDL-C from baseline

QUANTITY LIMITS

284mg administered initially, again at 3 months, and then every 6 months

etonorgestrel/ethinyl estradiol
(Nuvaring)

Contraception/ Oxytocics (March 2017)

CRITERIA

- Has inadequate response, intolerable side effect, or contraindication to formulary oral contraceptive or patient has known adherence/compliance issues

capsaicin 8% patch
(Qutenza)

Dermatology - Miscellaneous (June 2023)

CRITERIA

- Diagnosis of Diabetic Peripheral Neuropathy (DPN):
  - Has inadequate response, intolerable side effect, or contraindication to maximally tolerated doses of all the following medications:
    - Gabapentin
    - Pregabalin
    - Duloxetine
    - 1 agent from tricyclic antidepressants (TCA) (e.g., amitriptyline)
    - Over the counter capsaicin
    - Lidocaine 5% transdermal patches

- Diagnosis of Postherpetic Neuralgia (PHN):
  - Has inadequate response, intolerable side effect, or contraindication to maximally tolerated doses of all the following medications:
    - Gabapentin
    - Pregabalin
    - Duloxetine
    - 1 agent from tricyclic antidepressants (TCA) (e.g., amitriptyline)
    - Over the counter capsaicin
    - Lidocaine 5% transdermal patches

QUANTITY LIMITS

Initial approval: Max 4 patches for all sites combined in 90-day period.
Reauthorization: Up to 2 administrations (6 month approval period). Documentation that member has experienced an improvement in pain.

denosumab 120mg
(Xgeva)

Endocrine Disorder (October 2018)

CRITERIA

- Member using medication for one of the following:
    - Hypercalcemia of malignancy, bone metastases from solid tumors, or multiple myeloma with trial and failure of Zometa
    - Giant cell tumor of bone

QUANTITY LIMITS

120mg every 4 weeks
During the first month, may give an additional 120mg on Day 8 and Day 15

denosumab 60mg
(Prolia)

Endocrine Disorder (June 2024)

- Diagnosis of osteoporosis in male or postmenopausal female:
    - T-score of < -2.5 or history of osteoporotic fracture
        - And trial and failure of (or intolerance to) IV bisphosphonate [zoledronic acid]

- Diagnosis of osteoporosis in male or postmenopausal female:
    - T-score between −1.0 and −2.5 at the femoral neck or spine and a 10-yr probability of a hip fracture of ≥3% or a 10-yr probability of a major osteoporosis-related fracture of ≥20%
        - And trial and failure of (or intolerance to) IV bisphosphonate [zoledronic acid]

- Diagnosis of androgen deprivation-induced bone loss in men with prostate cancer:
    - And trial and failure of IV bisphosphonate [zoledronic acid]

- Diagnosis of aromatase inhibitor-induced bone loss in women with breast cancer:
    - And trial and failure of IV bisphosphonate [zoledronic acid]

QUANTITY LIMITS
60mg as a single dose, once every 6 months.

romosozumab-aqqg
(Evenity)

Endocrine Disorder (June 2024)

CRITERIA

- Osteoporosis in postmenopausal female as indicated by 1 of the following:
  - Femoral neck, spine, or total hip bone mineral density T-score - 2.5 or less
    - And trial and failure of zoledronic acid
    - And trial and failure of denosumab, teriparatide or abaloparatide
  - Hip or vertebral fragility fracture in patient older than 50 years
    - And trial and failure of zoledronic acid
    - And trial and failure of denosumab, teriparatide or abaloparatide
  - T-score between −1.0 and −2.5 at the femoral neck or spine and a 10-yr probability of a hip fracture of ≥3% or a 10-yr probability of a major osteoporosis-related fracture of ≥20%
    - And trial and failure of zoledronic acid
    - And trial and failure of denosumab, teriparatide or abaloparatide
  - Very high risk for fracture (T-score -3 or less, recent fracture within past 12 months, fractures while on approved osteoporosis therapy, multiple fractures, very high fracture probability by FRAX® (major osteoporosis fracture > 30%, hip fracture > 4.5%)

QUANTITY LIMITS

210 mg subcutaneously once every month for 12 doses
Max 12 doses

doxercalciferol
(Hectorol)

Endocrine Disorder (August 2016)

CRITERIA

- Diagnosis of secondary hyperparathyroidism due to chronic kidney disease (CKD)

histrelin acetate implant kit
(Supprelin LA)

Endocrine Disorder (October 2018)

CRITERIA

- Central precocious puberty (early-onset puberty):
    - Diagnosis of central precocious puberty confirmed by GnRH test or third-generation basal LH assay and
    - Ages 2-11 years if female, ages 2-12 years if male and
    - member has advanced bone age (bone age at least 1 yr greater than chronological age) and
    - Intracranial tumor has been ruled out and
    - Onset of secondary sex characteristics occurred at:
    - Age < 8 years if female
    - Age < 9 years if male and
    - Trial and failure of Lupron Depot*

*Prior Authorization Required

- Puberty suppression therapy for gender dysphoria:
    - Patient has been diagnosed with gender dysphoria disorder by a qualified mental health professional and
    - Patient has exhibited the first physical changes of puberty (Tanner stage 2 or 3) and
    - Trial and failure of Lupron Depot*

*Prior Authorization Required

QUANTITY LIMITS

A single, subcutaneous 50mg implant, once every 12 months.

leuprolide acetate
(Lupron Depot)

Endocrine Disorder (October 2018)

CRITERIA

- Dysfunctional Uterine Bleeding (off-label indication recommended by MCG guidelines):
    - Lupron is being used prior to planned endometrial ablation for definitive treatment and other causes of symptoms or bleeding ruled out (e.g., by endometrial biopsy)

- Endometriosis (Lupron Depot 3.75 monthly and/or 11.25 every 3 months – with max treatment of 6 months):
    - Diagnosis of endometriosis with symptoms as indicated by dysmenorrhea, dyspareunia or pelvic pain and
    - Must be 18 years or older and
    - Prescribed by an appropriate specialist (such as endocrinologist or OB/GYN) and
    - Patient has inadequate response, intolerable side effect, or contraindication to Orilissa*, NSAIDs, and oral contraceptives (at least 6 months trial)

*Prior Authorization Required

- Uterine Leiomyomas (fibroids) (Lupron Depot 3.75 monthly and/or 11.25 every 3 months – with Max treatment of 3 months):
    - Diagnosis of uterine leiomyomas with symptoms as indicated by abnormal uterine bleeding, bulk-related symptoms (e.g., pelvic pain or pressure, dyspareunia, urinary symptoms) or iron deficiency anemia and
    - Must be 18 years or older and
    - Other causes of symptoms or bleeding ruled out (e.g., by endometrial biopsy)

- Breast cancer (off-label indication recommended by MCG guidelines) (Lupron Depot 3.75 monthly and/or 11.25 every 3 months – with Max treatment of 24 months):
    - Palliative treatment of advanced disease and
    - Patient is premenopausal or perimenopausal

- Prostate Cancer (Lupron Depot 7.5 monthly, 22.5 every 3 months, 30 every 4 months, and 45 mg every 6 months):
    - Locally advanced (T3b to T4) or metastatic disease or
    - Clinically localized prostate cancer with intermediate risk of recurrence as indicated by 1 of the following:
        - T2a or lower, and aggressive histologic pattern (Gleason score of 7)
        - T2a or lower, and PSA 10 to 20 ng/mL (mcg/L)
        - T2b or T2c or
    - Clinically localized prostate cancer with high risk of recurrence as indicated by 1 of the following:
        - T2c or lower, and aggressive histologic pattern (Gleason score of 8 to 10)
        - T2c or lower, and PSA greater than 20 ng/mL (mcg/L)
        - T3a

- Central Precocious Puberty (early-onset puberty):
    - Diagnosis of central precocious puberty confirmed by GnRH test or third-generation basal LH assay and
    - Ages 2-11 years if female, ages 2-12 years if male and
    - Member has advanced bone age (bone age at least 1 yr greater than chronological age) and
    - Intracranial tumor has been ruled out and
    - Onset of secondary sex characteristics occurred at:
        - Age < 8 years if female
        - Age < 9 years if male

- Puberty Suppression Therapy for Gender Dysphoria:
    - Patient has been diagnosed with gender dysphoria disorder by a qualified mental health professional and
    - The patient has exhibited the first physical changes of puberty (Tanner stage 2 or 3)

repository corticotropin injection
(H.P. Acthar Gel)

Endocrine Disorder (August 2016)

CRITERIA

- Diagnosis of acute MS flare up in adults and:
    - Prescribed by neurologist
    - Currently on disease modifying therapy with adherence max doses of corticosteroids have been tried and failed during the current exacerbation, preferably trial of IV (e.g. methylprednisolone 500 to 1,000mg IV daily for 3-5 days)
    - A second opinion by an Alliance-identified American Board of Medical Specialties (ABMS) certified practitioner certified in the area of neurology may be required as well as assignment of an Alliance case manager (RN/MSW) to facilitate process in obtaining second opinion

- Diagnosis of any rheumatic disorder (RA, psoriatic arthritis, SLE, etc):
    - Prescribed by rheumatologist
    - Max doses of corticosteroids have been tried and failed during the current exacerbation

- Diagnosis of any Nephrotic Syndrome:
    - T/F corticosteroids (min 8 weeks) and if met, consult with Medical Director
    - Prescribed by Neurologist with diagnosis of infantile spasms
    - Less than 2 years of age
    - No CCS case

QUANTITY LIMITS
Maximum of 35mL in 28 days (each 5mL vial contains 400 units)

somatropin
(Human Growth Hormone: Genotropin, Humatrope, Norditropin, Nordiflex, Nutropin, Nutropin Aq, Nutropin Depot, Saizen, Serostim, Tev-Tropin, Zorbtive, Omnitrope, Genotropin, Humatrope, Norditropin, Nordiflex, Nutropin, Nutropin Aq, Nutropin Depot, Saizen, Serostim, Tev-Tropin, Zorbtive, Omnitrope)

Endocrine Disorder (August 2016)

CRITERIA

- Please see Milliman Health Care Guidelines (MCG)

triptorelin IM injection
(Triptodur)

Endocrine Disorder (January 2019)

CRITERIA

- Central precocious puberty (early-onset puberty):
    - Diagnosis of central precocious puberty
    - Confirmed by GnRH test or third-generation basal LH assay
    - Ages 2-11 years if female, ages 2-12 years if male
    - Member has advanced bone age (bone age at least 1 yr greater than chronological age)
    - Intracranial tumor has been ruled out
    - Onset of secondary sex characteristics occurred at:
        - Age < 8 years if female
        - Age < 9 years if male
    - Trial and failure of Lupron Depot*

*Prior Authorization Required

- Puberty suppression therapy for gender dysphoria:
    - The patient has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria
    - Gender dysphoria emerged or worsened with the onset of puberty
    - Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment
    - The patient has exhibited the first physical changes of puberty (Tanner stage 2 or 3)
    - Trial and failure of Lupron Depot*

*Prior authorization required

QUANTITY LIMITS
22.5 mg IM injection once every 6 months

triptorelin pamoate intramuscular injection
(Trelstar Depot)

Endocrine Disorder (October 2018)

CRITERIA

- Medication is being used for the palliative treatment of prostate cancer

etelcalcetide
(Parsabiv)

Endocrine Disorder (August 2020)

CRITERIA

- Diagnosis of secondary hyperparathyroidism in adult CKD and all of the following:
    - Patient is on hemodialysis
    - serum calcium level (corrected for albumin) at or above the lower limit of normal prior to initiation (≥ 8.4 mg/dL) and
    - Current intact parathyroid hormone levels are greater than 300 pg/ml
    - Tried and failed one phosphate binder

dexamethasone 0.7 mg intravitreal implant
(Ozurdex)

Eye- General Disorders (May 2019)

CRITERIA

- Diagnosis of diabetic macular edema:
    - Has inadequate response, intolerable side effect, or contraindication to anti-VEGF (bevacizumab*, ranibizumab*, aflibercept*) and
    - Inadequate response to intravitreal triamcinolone*

*Prior authorization required

- Diagnosis of non-infective uveitis:
    - Has inadequate response, intolerable side effect, or contraindication to a topical corticosteroid (such as prednisolone) and
    - Inadequate response to intravitreal triamcinolone*

*Prior authorization required

fluocinolone 0.18 mg intravitreal implant
(Yutiq)

Eye- General Disorders (May 2019)

CRITERIA

- Diagnosis of chronic non-infective uveitis:
    - Has inadequate response, intolerable side effect, or contraindication to a topical corticosteroid (such as prednisolone) and
    - Inadequate response to intravitreal triamcinolone*

*Prior authorization required

fluocinolone 0.59 mg intravitreal implant
(Retisert)

Eye- General Disorders (May 2019)

CRITERIA

- Diagnosis of chronic non-infective uveitis:
    - Has inadequate response, intolerable side effect, or contraindication to a topical corticosteroid (such as prednisolone) and
    - Inadequate response to intravitreal triamcinolone* and
    - Has inadequate response, intolerable side effect, or contraindication to Yutiq*

*Prior authorization required

ocriplasmin 1.25mg/ml intraocular vial
(Jetrea)

Eye- General Disorders (October 2018)

CRITERIA

- Diagnosis of symptomactic vitreomacular adhesion documented on Optical Coherence Tomography (OCT):
    - Must be prescribed by an retinal specialist, or an ophthalmologist and
    - Must not have had a prior vitrectomy and
    - Must not be receiving treatment in both eyes within 7 days of each other and
    - Must not have a prior treatment with Jetrea on the affected eye

QUANTITY LIMITS

1 injection per eye, per lifetime

triamcinolone intravitreal injection
(Triesence)

Eye- General Disorders (May 2019)

CRITERIA

- Diagnosis of macular edema:
    - Has inadequate response, intolerable side effect, or contraindication to at least one anti-VEGF (such as bevacizumab*, ranibizumab*, or aflibercept*)

*Prior authorization required

- Diagnosis of inflammatory ocular condition:
    - Has inadequate response, intolerable side effect, or contraindication to a topical corticosteroid (such as prednisolone)

fluocinolone implant
(Iluvien)

Eye- Miscellaneous (June 2018)

CRITERIA

- Diagnosis of diabetic macular edema:
    - Has inadequate response, intolerable side effect, or contraindication to anti-VEGF (bevacizumab*, ranibizumab*, aflibercept*) and
    - Inadequate response to intravitreal triamcinolone* and
    - Previously treated with a course of intravitreal corticosteroid and did not have clinically significant rise in intraocular pressure

*Prior authorization required

QUANTITY LIMITS

One implant (0.19mg fluocinolone acetonide) per eye

One implant per eye every 3 years

hydroxypropyl cellulose ophthalmic insert
(Lacrisert)

Eye- Miscellaneous (May 2019)

CRITERIA

- Diagnosis of keratoconjunctivitis sicca, exposure keratitis, decreased corneal sensitivity, or recurrent corneal erosions:
    - Has inadequate response, intolerable side effect, or contraindication to Restasis* and
    - Xiidra* and
    - Cequa* for 60 days and
    - Evaluated by ophthalmologist or optometrist

*Prior Authorization Required

QUANTITY LIMITS
Box of 60 inserts per prescription

ranibizumab ophthalmic injection
(Lucentis)

Eye- Miscellanous (June 2024)

CRITERIA

- Diagnosis of age-related macular degeneration (neovascular), diabetic macular edema, diabetic retinopathy, macular edema following retinal vein occlusion, myopic choroidal neovascularization and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections*

*Prior authorization required

ranibizumab-eqrn ophthalmic injection
(Cimerli)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration (neovascular), diabetic macular edema, diabetic retinopathy, macular edema following retinal vein occlusion, myopic choroidal neovascularization and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab

ranibizumab-nuna ophthalmic injection
(Byooviz)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration (neovascular), macular edema following retinal vein occlusion, myopic choroidal neovascularization and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab

ranibizumab for intravitreal use via ocular implant
(Susvimo)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration (neovascular) within the prior 9 months and
    - Has received 3 or more doses of anti-VEGF intravitreal agents in the affected eye within the prior 6 months and
    - Demonstrated a response to anti-VEGF intravitreal agent bevacizumab* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab

aflibercept 2 mg/0.05 ml solution for intravitreal injection
(Eylea, Pavblu, Enzeevu, Ahzantive)

Eye- Miscellaneous (June 2025)

CRITERIA

- Diagnosis of age-related macular degeneration, diabetic macular edema, diabetic retinopathy, macular edema, retinopathy of prematurity and
    - No active intraocular inflammation or infection and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab.

aflibercept 8 mg/0.07 ml solution ophthalmic injection
(Eylea HD)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration, diabetic macular edema, diabetic retinopathy and
    - No active intraocular inflammation or infection and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab

brolucizumab-dbll ophthalmic injection
(Beovu)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration (neovascular (wet) age-related macular degeneration and diabetic macular edema
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injections* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab.

faricimab-svoa ophthalmic injection
(Vabysmo)

Eye- Miscellaneous (March 2025)

CRITERIA

- Diagnosis of age-related macular degeneration, diabetic macular edema, macular edema following retinal vein occlusion and
    - No active intraocular inflammation or infection and
    - Has inadequate response, intolerable side effect, or contraindication to bevacizumab injection* and Lucentis**

*Prior authorization required

** Prior Authorization required. Subject to trial and failure of bevacizumab

filgrastim
(Neupogen)

Hematological Disorders (December 2024)

CRITERIA

- Diagnosis of non-myeloid malignancies and:
    - Receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia and
    - Medical justification as to why Granix, Nivestym, Zarxio or Releuko cannot be used

oprelvekin
(Neumega)

Hematological Disorders (August 2016)

CRITERIA

- Diagnosis is treatment or prophylaxis of thrombocytopenia following chemotherapy and documentation of the following:
    - Diagnosis of non-myeloid malignancy
    - Platelets ≤ 20,000/µL or documented past incidence(s) of platelets ≤ 20,000/µL

QUANTITY LIMITS

50 mcg/kg once daily X 21 days max

CrCl ≤ 30 mL/min

25mcg/kg once daily X 21 days max

pegfilgrastim
(Fulphila, Udenyca, Ziextenzo, Stimufend, Fylnetra, Nyvepria)

Hematological Disorders (December 2024)

CRITERIA

- Diagnosis of non-myeloid malignancies and:
    - Receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia and
    - Medical justification as to why preferred Neulasta (pegfilgrastim) cannot be used

eflapegrastim-xnst
(Rolvedon)

Hematological Disorders (March 2025)

CRITERIA

- Diagnosis of non-myeloid malignancies and:
  - Receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia and
  - ≥ 18 years of age and
  - Medical justification as to why Neulasta (pegfilgrastim) cannot be used and
  - Medical justification as to why Fulphila*, Udenyca*, Ziextenzo*, Stimufend*, Fylnetra* or Nyvepria* cannot be used

*Prior authorization required

efbemalenograstim
(Ryzneuta)

Hematological Disorders (March 2025)

CRITERIA

- Diagnosis of non-myeloid malignancies and:
  - Receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia and
  - ≥ 18 years of age and
  - Medical justification as to why Neulasta (pegfilgrastim) cannot be used and
  - Medical justification as to why Fulphila*, Udenyca*, Ziextenzo*, Stimufend*, Fylnetra* or Nyvepria* cannot be used

*Prior authorization required

Immunization/vaccines

Immunization (October 2018)

CRITERIA

- For member under 19 years of age:
    - Routine vaccines to be administered by VFC provider in accordance with the Advisory Committee on Immunization Practices (ACIP).

- For members who are 19 years of age or older:
    - Routine vaccines in accordance with ACIP

- Prior Authorization Required for Travel vaccines and will be covered if recommended by ACIP or if medically necessary based on CDC (Centers for Disease Control and Prevention) recommendations

basiliximab vial
(Simulect)

Immunosuppresion/ Modulation (October 2018)

CRITERIA

- For prophylaxis of organ rejection in a patient undergoing kidney transplant and:
    - Prescribed by a physician experienced in immunosuppressive therapy and management of kidney transplant patients and
    - Used in combination with other immunosuppressants

belatacept 250ml vial
(Nulojix)

Immunosuppresion/ Modulation (October 2018)

CRITERIA

- For prophylaxis of organ rejection in a patient undergoing kidney transplant and:
    - Patient has no history of liver transplant and
    - Patient has Epstein-Barr virus (EBV) seropositive result and
    - Prescribed by a physician experienced in immunosuppressive therapy and management of kidney transplant patients and
    - Patient must not be able to use tacrolimus or cyclosporine because of a drug allergy or intolerance/toxicity and
    - Used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids

isavuconazonium sulfate
(Cresemba)

Infectious Disease – Fungal (June 2019)

CRITERIA

- Prescribed by or in consultation with infectious disease specialist and:
    - Diagnosis of invasive Aspergillosis and
    - Has inadequate response, intolerable side effect, or contraindication to voriconazole or other documented medical justification why voriconazole or itraconazole cannot be used and
    - Has inadequate response, intolerable side effect, or contraindication to or other documented medical justification why amphotericin B liposome (IV – when feasible) cannot be used

- Prescribed by or in consultation with infectious disease specialist and:
    - Diagnosis of Mucormycosis

posaconazole
(Noxafil)

Infectious Disease – Fungal (June 2019)

CRITERIA

- Prescribed by or in consultation with infectious disease specialist and:
    - Diagnosis of non-invasive Aspergillosis
    - Has inadequate response, intolerable side effect, or contraindication to voriconazole or other documented medical justification why voriconazole cannot be used

- Diagnosis of invasive Aspergillosis

- Diagnosis of Candidiasis or empirical treatment of invasive Candidiasis and:
    - Has inadequate response, intolerable side effect, or contraindication to fluconazole or other documented medical justification why fluconazole cannot be used

amphotericin b, amphotericin b lipid complex, amphotericin b liosome (Amphotericin B, Abelce, Ambisome)

Infectious Disease – Fungal (August 2016)

CRITERIA

- Prescribed by or in consultation with infectious disease specialist and:
    - Diagnosis of invasive Aspergillosis, or Cryptococal systemic fungal infection

- Diagnosis of Candida prophylaxis or Candidiasis and:
    - Has inadequate response, intolerable side effect, or contraindication to fluconazole or other documented medical justification why fluconazole cannot be used

QUANTITY LIMITS

Amphotericin B
0.5-1mg/kg daily

Lipid formulation
3-5mg/kg daily

vancomycin (IV)

Infectious Disease – Misellaneous (June 2021)

CRITERIA

- Treatment of infection against aerobic gram-positive bacteria and is not being used for Clostridium difficile infections

QUANTITY LIMITS

Variable per renal function

palivizumab
(Synagis)

Infectious Disease – Viral (August 2016)

CRITERIA

- Refer to current American Academy of Pediatrics (AAP) recommendations

tedizolid phosphate
(Sivextro)

Infectious Disease – Bacterial (June 2017)

CRITERIA

- Approvable for member who have been started and stabilized on Sivextro (oral or IV) while in the hospital or ER

- Physician must submit documentation of acute skin and skin structure MRSA (Methicillin resistant staphylococcus aureus) infection with culture and documented sensitivity to Sivextro

- Physician must submit documentation of an infection with culture and documented sensitivity to Sivextro and:
    - The organism being treated must be resistant or not susceptible to
    - Or member have contraindications, intolerable side effects, or drug-drug interactions with the preferred first line antibiotics for that organism (Current IDSA guidelines).

QUANTITY LIMITS
1/day

abatacept
(Orencia)

Inflammatory Disease (March 2018)

CRITERIA

- Diagnosis of rheumatoid arthritis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or
  - Has severe active rheumatoid arthritis

- Diagnosis of juvenile idiopathic arthritis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or
  - Has polyarthropathy

- Diagnosis of psoriatic arthritis and:
  - Has been evaluated by a rheumatologist/dermatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or apremilast or
  - Severe active psoriatic arthritis (axial disease – sacroiliitis or spondylitis)

QUANTITY LIMITS

RA/JIA/PsA:
IV: Based on weight(500mg-1000mg)
Wk 0: 500mg
Wk 2: 500mg
Wk 4: 500mg
and every 4 weeks thereafter
SC: 125mg/wk

certolizumab, pegol
(Cimzia)

Inflammatory Disease (May 2019)

CRITERIA

- Diagnosis of rheumatoid arthritis:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate , hydroxychloroquine, leflunomide, or sulfasalazine) or
  - Has severe active rheumatoid arthritis.

- Diagnosis of psoriatic arthritis:
  - Has been evaluated by a rheumatologist/dermatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate , hydroxychloroquine, leflunomide, or sulfasalazine) or apremilast or
  - Severe active psoriatic arthritis (axial disease – sacroiliitis or spondylitis)

- Diagnosis of ankylosing spondylitis:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to 2 formulary NSAIDs or steroids

- Diagnosis of moderate to severe Crohn's disease:
  - Has been evaluated by a gastroenterologist and
  - Has inadequate response, intolerable side effect, or contraindication to azathioprine, mercaptopurine or methotrexate or
  - Has severe or refractory disease or
  - Perianal fistulizing disease

QUANTITY LIMITS
RA/PsA/AS loading dose:
Wk 0: 400mg
Wk 2: 400mg
Wk 4: 400mg

Maintenance dose:
200mg every 2 wks or 400mg every 4 weeks

Crohn's Induction Dose:
Wk 0: 400mg
Wk 2: 400mg
Wk 4: 400mg

Maintenance dose:
400mg every 4 weeks

triamcinolone Injection – intraarticular
(Zilretta, PRO-C-DURE 5, PRO-C-DURE 6)

Inflammatory Disease (April 2021)

CRITERIA

- Diagnosis of osteoarthritis of the knee and:
    - Has been evaluated by a rheumatologist or orthopedic specialist and
    - Has inadequate response, intolerable side effect, or contraindication to a 10-12-week trial of full-dose nonsteroidal anti-inflammatory drug (NSAID) therapy, with or without supplemental acetaminophen or topical nonsteroidal anti-inflammatory drug (NSAID) if unable to tolerate oral form and
    - Has inadequate response, intolerable side effects to at least two different intra-articular steroid injections (e.g. triamcinolone, methylprednisolone, betamethasone, dexamethasone).

QUANTITY LIMITS

Single intra-articular injection to deliver 32 mg (5 ml) per knee.

triamcinolone acetonide
(Kenalog-10, Kenalog-40)

Inflammatory Disease (June 2025)

CRITERIA

- Diagnosis of alopecia areata hair loss on scalp and
- Evaluated by appropriate specialist such as a dermatologist

belimumab
(Benlysta)

Inflammatory Disease (October 2018)

CRITERIA

- Diagnosis of active systemic lupus erythematosus:
    - Currently on and has had an inadequate response or intolerance to standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate, hydroxychloroquine)
    - Member does not have severe active lupus nephritis or severe active central nervous system (CNS) lupus

c1 esterase inhibitor, human
(Berinert)

Inflammatory Disease (March 2018)

CRITERIA

- Member must meet all of the following criteria:
    - The medication is being used for treatment of acute hereditary angioedema (HAE) attacks
    - Must be prescribed by, or in consultation with, a specialist (i.e. allergist, immunologist, hematologist, pulmonologist, etc)
    - Patient must be at least 5 years old and
    - Member must have at least one of the following clinical presentations (confirmed by testing):
        - HAE I (C1-Inhibitor deficiency)
        - HAE II (C1-Inhibitor dysfunction)
        - HAE with normal C1INH (also known as HAE III)

golimumab
(Simponi & Simponi Aria)

Inflammatory Disease (March 2018)

CRITERIA

- Diagnosis of rheumatoid arthritis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine)
  - Or has severe active rheumatoid arthritis

- Diagnosis of psoriatic arthritis and:
  - Has been evaluated by a rheumatologist/dermatologist and
  - Has inadequate response, intolerable side effect, or contraindication one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or apremilast
  - Or severe active psoriatic arthritis (axial disease – sacroiliitis or spondylitis)

- Diagnosis of ankylosing spondylitis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to 2 formulary NSAIDs or steroids

- Diagnosis of moderate to severe ulcerative colitis and:
  - Has been evaluated by a gastroenterologist and
  - Has inadequate response, intolerable side effect, or contraindication to systemic aminosalicylates (sulfasalazine, mesalamine), azathioprine or mercaptopurine
  - Or has severe or refractory disease

QUANTITY LIMITS
RA/PsA/AS: 50mg SQ once monthly

RA/PsA/AS: Simponi Aria: 2mg/kg IV at weeks 0 and 4, then every 8 weekls

UC Induction Dose:
Wk 0: 200mg
Wk 2: 100mg

UC Maintenance Dose:
100mg every 4 weeks

hyaluronic acid intra-articular injection (viscosupplements)
(Durolane, Euflexxa, Gel-One, Gelsyn-3, Genvisc 850, Supartz, Supartz Fx, Hyalgan, Hymovisc, Monovisc, Orthovisc, Synvisc, Synvisc-One, Trivisc, Visco-3)

Inflammatory Disease (June 2024)

CRITERIA

- Diagnosis of osteoarthritis of the knee (any other use is considered experimental, investigational, or unproven, including osteoarthritis of hip, osteoarthritis of shoulder) and
    - Member must have been evaluated by an appropriate specialist and
    - Has inadequate response, intolerable side effect, or contraindication to acetaminophen and a prescription strength nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen, naproxen, celecoxib etc. and
    - If member is intolerant to oral NSAID, they must have 3 months trial of topical NSAID and
    - Trial and failure of physical therapy and
    - Documentation of 2 intra-articular steroid injections within the last year and documentation of response to the treatment or complete lack of response to less than 2 injections (effects lasting less than 6-8 weeks)
    - Member does not have any other diagnosis contributing to their knee pain

QUANTITY LIMITS

Limit approval to one course per knee per 6 months

For re-authorization, documentation that patient has successfully used hyaluronic acid derivatives in the same knee (there must be at least a six-month interval before approval of a repeat course).

tocilizumab
(Actemra)

Inflammatory Disease (March 2018)

CRITERIA

- Diagnosis of rheumatoid arthritis and:
    - Has been evaluated by a rheumatologist and
    - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine)
    - Or has severe active rheumatoid arthritis

- Diagnosis of juvenile idiopathic arthritis and:
    - Has been evaluated by a rheumatologist and
    - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine)
    - Or has polyarthropathy

QUANTITY LIMITS

IV: 4-8mg/kg every 4 weeks

SC: 162mg

If < 100kg, 162mg every other week
If >100kg, 162mg every week

infliximab
(Remicade, Avsola [infliximab-axxq], Inflectra [infliximab-dyyb], Renflexis [infliximab-abda], Zymfentra [infliximab-dyyb])

Inflammatory Disease (September 2024)

CRITERIA

- Diagnosis of rheumatoid arthritis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine)
  - Or has severe active rheumatoid arthritis

- Diagnosis of psoriatic arthritis and:
  - Has been evaluated by a rheumatologist/dermatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or apremilast
  - Or severe active psoriatic arthritis (axial disease – sacroiliitis or spondylitis)

- Diagnosis of ankylosing spondylitis and:
  - Has been evaluated by a rheumatologist and
  - Has inadequate response, intolerable side effect, or contraindication to 2 formulary NSAIDs or steroids

- Diagnosis of moderate to severe plaque psoriasis and:
  - Psoriasis affects > 10% BSA or causes significant functional disability (Palms, soles, genitalia, severe scalp psoriasis) and
  - Has inadequate response, intolerable side effect, or contraindication to phototherapy (if available) and
  - Has inadequate response, intolerable side effect, or contraindication to acitretin or another DMARD

- Diagnosis of moderate to severe Crohn's disease or perianal fistulizing disease and:
  - Has been evaluated by a gastroenterologist

- Diagnosis of moderate to severe ulcerative colitis and:
  - Has been evaluated by a gastroenterologist

ustekinumab
(Stelara, Wezlana [ustekinumab-auub], Pyzchiva [ustekinumab-ttwe], Selarsdi [ustekinumab-aekn])

Inflammatory Disease (March 2025)

CRITERIA

- Diagnosis of psoriatic arthritis and:
  - Has been evaluated by a rheumatologist/dermatologist and
  - Has inadequate response, intolerable side effect, or contraindication to one DMARD (such as methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine) or apremilast and
  - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*)

*Prior authorization required

- Diagnosis of moderate to severe plaque psoriasis and:
  - Psoriasis affects > 10% BSA or causes significant functional disability disability (Palms, soles, genitalia, severe scalp psoriasis) and
  - Has inadequate response, intolerable side effect, or contraindication to phototherapy (if available) and
  - Has inadequate response, intolerable side effect, or contraindication to acitretin or another DMARD and
  - Has inadequate response, intolerable side effects to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*)

*Prior authoirzation required

- Diagnosis of moderate to severe Crohn's disease and:
  - Has been evaluated by a gastroenterologist and
  - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

- Diagnosis of moderate to severe ulcerative colitis and:

- Has been evaluated by a gastroenterologist and
- Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

QUANTITY LIMITS
PsA and Psoriasis
If <100kg:
Wk 0: 45mg
Wk 4: 45mg and 45mg every 12 weeks thereafter
If >100kg:
Wk 0:90mg
Wk 4:90mg and 90mg every 12 weeks thereafter

Crohn Disease:
Induction: 55kg or less:
Wk 0: 260mg
55kg to 85 kg
Wk 0: 390mg
More than 85kg
Wk 0: 520mg
Maintenance: 90mg every 8 weeks.

vedolizumab
(Entyvio)

Lower Gastrointestional Disorders – Bowel Inflammatory (September 2024)

CRITERIA

- Diagnosis of moderate to severe Crohn's disease and:
    - Has been evaluated by a gastroenterologist and
    - Has inadequate response, intolerable side effects to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

- Diagnosis of moderate to severe ulcerative colitis and:
    - Has been evaluated by a gastroenterologist and
    - Has inadequate response, intolerable side effects to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

QUANTITY LIMITS
Crohn's/UC
Induction dose:
Wk 0: 300mg
Wk 2: 300mg
Wk 6: 300mg

Maintenance dose:
300mg every 8 weeks

mirikizumab-mrkz
(Omvoh)

Lower Gastrointestinal Disorders – Bowel Inflammatory (June 2025)

CRITERIA

- Diagnosis of moderate to severe ulcerative colitis and:
    - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

- Diagnosis of moderate to severe Crohn's disease and:
    - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

QUANTITY LIMITS

UC
IV Induction dose:
Wk 0: 300mg
Wk 4: 300mg
Wk 8: 300mg
Maintenance dose: 200mg SQ at week 12, then every 4 weeks thereafter

Crohn's
IV Induction dose:
Wk 0: 900mg
Wk 4: 900mg
Wk 8: 900mg
Maintenance dose: 300mg SQ at week 12, then every 4 weeks thereafter

risankizumab-rzaa
(Skyrizi)

Lower Gastrointestinal Disorders – Bowel Inflammatory (June 2025)

CRITERIA

- Diagnosis of moderate to severe Crohn's disease and:
    - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

- Diagnosis of moderate to severe Ulcerative colitis and:
    - Has inadequate response, intolerable side effect, or contraindication to a tumor necrosis factor-alpha inhibitor (e.g., adalimumab*, etanercept*, infliximab*) or provide medical justification for the requested drug over a tumor necrosis factor-alpha inhibitor

*Prior authorization required

QUANTITY LIMITS

Crohn's
IV Induction dose:
Wk 0: 600mg
Wk 4: 600mg
Wk 8: 600mg
Maintenance dose SQ: Pre-filled cartridge 180mg-360mg SQ at week 12 and every 8 weeks thereafter

UC
IV Induction dose:
Wk 0: 1200mg
Wk 4: 1200mg
Wk 8: 1200mg
Maintenance dose: Prefilled cartridge 180mg-360mg SQ at week 12 and every 8 weeks thereafter

alemtuzumab
(Lemtrada)

Neurological Disease – Miscellaneous (June 2024)

CRITERIA

- Diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) and:
    - ≥ 18 years of age and
    - Evaluated by a neurologist and
    - Trial and failure of two or more medications indicated for the treatment of multiple sclerosis such as ocrelizumab (Ocrevus)*, natalizumab (Tysabri)*, or ublituximab-xiiy (Briumvi)*.

*Prior authorization required

ublituximab-xiiy
(Briumvi)

Neurological Disease – Miscellaneous (June 2024)

CRITERIA

- Diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) and:
    - ≥ 18 years of age and
    - Evaluated by a neurologist

natalizumab
(Tysabri)

Neurological Disease – Miscellaneous (June 2024)

CRITERIA

- Diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) and:
    - ≥ 18 years of age and
    - Evaluated by a neurologist and
    - Has been tested for anti-JCV antibodies and results are negative

- Diagnosis of Crohn's Disease and:
    - ≥ 18 years of age and
    - Evaluated by a gastroenterologist and
    - Has been tested for anti-JCV antibodies and results are negative and
    - Has tried and failed at least one tumor necrosis factor (TNF)-blocker indicated for Crohn's disease such as adalimumab* or infliximab*

*Prior authorization required

QUANTITY LIMITS
Crohn's/MS:
300mg IV every 4 weeks

ocrelizumab
(Ocrevus)

Neurological Disease – Miscellaneous (June 2024)

CRITERIA

- Diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease) and:
    - ≥ 18 years of age and
    - Evaluated by a neurologist

- Diagnosis of primary progressive multiple sclerosis and:
    - ≥ 18 years of age and
    - Evaluated by a neurologist

levocarnitine
(Carnitor)

Other Drugs (August 2016)

CRITERIA

- Diagnosis of levocarnitine deficiency

octreotide depot form (for injectable suspension); octreotide acetate lar depot (Sandostatin LAR Depot)

Other Drugs (October 2018)

CRITERIA

- Diagnosis of Acromegaly and:
    - Member has a high pretreatment IGF-1 level for age and/or gender and
    - Member had an inadequate or partial response to surgery or radiotherapy or there is a clinical reason why the member has not had surgery or radiotherapy and
    - Member who have responded to and tolerated subcutaneous octreotide and have medical justification for switching to long acting depot form

- For treatment of gastroenteropancreatic neuroendocrine tumors or carcinoid syndrome based on NCCN guidelines

onabotulinumtoxina
(Botox)

Other Drugs (October 2018)

CRITERIA

- Diagnosis of migraine headaches lasting 4 hours a day or longer with frequency occurring 15 or more days per month for 3 or more months and:
    - Has inadequate response, intolerable side effect, or contraindication to 3 preventative formulary medications x 12 weeks or complete intolerance, including:
        - 1 agent from beta-blockers (e.g., atenolol, propranolol, metoprolol)
        - 1 agent from tricyclic antidepressants (TCA) (e.g., amitriptyline) and
        - 1 agent from anticonvulsants (e.g., divalproex, topiramate)

QUANTITY LIMITS

Max dose: 200-units every 12 weeks (84-days)

baclofen intrathecal
(Lioresal Intrathecal (IT))

Skeletal Muscle Disorder (October 2018)

CRITERIA

- Must have severe spasticity of spinal or cerebral origin (multiple sclerosis, cerebral palsy, spinal cord injury, or traumatic brain) and:
    - Age > 4 years and
    - Documentation of unacceptable side effects from or intolerance to oral baclofen at an effective dose or documentation of unresponsiveness or ineffectiveness to maximal dosing of oral baclofen and
    - Must have a positive response to a screening trial and
    - Must be prescribed by a neurologist

collagenase clostridium histolyticum 0.9mg vial (Xiaflex)

Skeletal Muscle Disorder (October 2018)

CRITERIA

- For the treatment of adult patients with Dupuytren's contracture with a palpable cord.

ferric carboxymaltose
(Injectafer)

Vitamin and/ or Mineral Deficiency (September 2017)

CRITERIA

- Diagnosis of iron-deficiency anemia and:
    - Laboratory evidence of iron deficiency anemia and
    - Has inadequate response, intolerable side effect or contraindication to oral iron therapy and
    - Has inadequate response, intolerable side effect or contraindication to 1 of the 3 preferred alternatives: iron sucrose, sodium ferric gluconate or iron dextran

QUANTITY LIMITS

750mg IV infusion for 2 doses per course of therapy

ferumoxytol
(Feraheme)

Vitamin and/ or Mineral Deficiency (September 2017)

CRITERIA

- Diagnosis of iron-deficiency anemia and:
    - Laboratory evidence of iron deficiency anemia and
    - Has inadequate response, intolerable side effect or contraindication to oral iron therapy and
    - Has inadequate response, intolerable side effect or contraindication to 1 of the 3 preferred alternatives: iron sucrose, sodium ferric gluconate or iron dextran

QUANTITY LIMITS

510mg IV infusion for 2 doses per course of therapy

ferric derisomaltose
(Monoferric)

Vitamin and/ or Mineral Deficiency (June 2023)

CRITERIA

- Diagnosis of iron-deficiency anemia:
    - Laboratory evidence of iron deficiency anemia and
    - Has inadequate response, intolerable side effect or contraindication to oral iron therapy and
    - Has inadequate response, intolerable side effect or contraindication to 1 of the 3 preferred alternatives: iron sucrose, sodium ferric gluconate or iron dextran and
    - Has inadequate response, intolerable side effect or contraindication to ferric carboxymaltose (Injectafer)*

*Prior authorization required

QUANTITY LIMITS

1000mg IV infusion for 1 dose per course of therapy