



NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Analgesic Agents: Opioids	Nucynta IR, ER
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Enalapril Sol
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Imitrex Nasal Spray Tosymra
Central Nervous System (CNS) Agents: Anticonvulsants*	Lamictal ODT Trileptal Susp
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Dyanavel XR Procentra
Gastrointestinal Agents: Ulcerative Colitis	Mesalamine DR Tab
Infectious Disease Agents: Antivirals – HIV*	Lopinavir/Ritonavir Ritonavir Tab Symtuza
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	Bepreve
Ophthalmic Agents: Glaucoma Agents	Alphagan P 0.1%
Ophthalmic Agents: Ophthalmic Steroids	Alrex Flarex Lotemax Maxidex Pred Forte
Respiratory Agents: Inhaled Agents	Proventil HFA

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED
Analgesic Agents: Gout	Colcrys Tab
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Nivestym
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Hemangeol
Endocrine Agents: Growth Hormone	Genotropin
Endocrine Agents: Uterine Fibroids	Myfembree
Immunomodulator Agents: Systemic Inflammatory Disease	Adbry Dupixent
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Dupixent



NEW STEP THERAPY PREFERRED DRUGS	
THERAPEUTIC CLASS	STEP THERAPY REQUIRED PREFERRED
Central Nervous System (CNS) Agents: Anticonvulsants*	Epidiolex Lacosamide
Central Nervous System (CNS) Agents: Movement Disorders	Austedo
Endocrine Agents: Endometriosis	Myfembree
Gastrointestinal Agents: Unspecified GI	Trulance

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Analgesic Agents: Gout	Probenecid/Colchicine Febuxostat Mitigare
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Releuko Ziextenzo
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Aspruzyo Sprinkle Camzyos Epaned Norliqva
Central Nervous System (CNS) Agents: Alzheimer's Agents*	Adlarity
Central Nervous System (CNS) Agents: Anti- Migraine Agents, Acute	Sumatriptan Nasal Spray
Central Nervous System (CNS) Agents: Anticonvulsants*	Qudexy XR Vimpat
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Focalin XR
Central Nervous System (CNS) Agents: Atypical Antipsychotics	Risperdal
Central Nervous System (CNS) Agents: Sedative- Hypnotics, Non-Barbiturate	Quviviq
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Lyvispah
Dermatologic Agents: Topical Acne Products	Epsolay
Endocrine Agents: Diabetes – Non-Insulin	Mounjaro
Endocrine Agents: Growth Hormone	Omnitrope
Gastrointestinal Agents: Ulcerative Colitis	Lialda
Infectious Disease Agents: Antibiotics – Inhaled	Arikayce
Infectious Disease Agents: Antibiotics – Tetracyclines	Demeclocycline
Infectious Disease Agents: Antivirals – HIV	Kaletra Norvir Tabs
Respiratory Agents: Inhaled Agents	Formoterol Fumarate Nebulizer Sol



Respiratory Agents: Monoclonal Antibodies- Anti-IL/Anti-IgE	Nucala
Topical Agents: Immunomodulators	Vtama

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA	
Analgesic Agents: Gout	
Analgesic Agents: Opioids	
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors*	
Cardiovascular Agents: Angina, Hypertension & Heart Failure	
Cardiovascular Agents: Lipotropics	
Cardiovascular Agents: Pulmonary Arterial Hypertension*	
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	
Central Nervous System (CNS) Agents: Anticonvulsants*	
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	
Central Nervous System (CNS) Agents: Movement Disorders	
Central Nervous System (CNS) Agents: Narcolepsy	
Endocrine Agents: Androgens	
Endocrine Agents: Diabetes – Insulin	
Endocrine Agents: Diabetes – Non-Insulin	
Endocrine Agents: Endometriosis	
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	
Endocrine Agents: Uterine Fibroids	
Gastrointestinal Agents: Crohn’s Disease	
Gastrointestinal Agents: Hepatic Encephalopathy	
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	
Gastrointestinal Agents: Proton Pump Inhibitors	
Gastrointestinal Agents: Ulcerative Colitis	
Gastrointestinal Agents: Unspecified GI	
Genitourinary Agents: Benign Prostatic Hyperplasia	
Immunomodulator Agents: Systemic Inflammatory Disease	
Infectious Disease Agents: Antibiotics – Cephalosporins	
Infectious Disease Agents: Antibiotics – Inhaled	
Infectious Disease Agents: Antibiotics – Macrolides	
Infectious Disease Agents: Antibiotics – Quinolones	
Infectious Disease Agents: Antibiotics – Tetracyclines	
Infectious Disease Agents: Antifungals	
Infectious Disease Agents: Antivirals – Hepatitis C Agents	
Infectious Disease Agents: Antivirals – HIV*	
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	



Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers
Ophthalmic Agents: Dry Eye Treatments
Ophthalmic Agents: Glaucoma Agents
Ophthalmic Agents: NSAIDs
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations
Respiratory Agents: Antihistamines – Second Generation
Respiratory Agents: Cystic Fibrosis
Respiratory Agents: Hereditary Angioedema
Respiratory Agents: Inhaled Agents
Respiratory Agents: Nasal Preparations
Respiratory Agents: Other Agents
Topical Agents: Antifungals
Topical Agents: Antiparasitics

REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Analgesic Agents: Gout	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one preferred drug</u>
Analgesic Agents: Opioids	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>7 days</u> of at least <u>two unrelated</u> preferred drugs <p>ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA FOR NEW STARTS:</p> <ul style="list-style-type: none"> Subsequent short-acting requests can be authorized up to 180 days <ul style="list-style-type: none"> Documentation of the following must be provided: <ul style="list-style-type: none"> Current treatment plan Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed Dose escalation requests can be authorized up to 180 days <ul style="list-style-type: none"> Documentation of the following must be provided: <ul style="list-style-type: none"> Prescriber attestation that dose escalation is likely to result in improved function and pain control Requests for a cumulative daily dose >100 MED must be prescribed by or in consultation with a pain specialist or anesthesiologist consultation <p>ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:</p> <ul style="list-style-type: none"> The system defines an “initial request” as having no opioid claims in the previous 90 days



<p>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors*</p>	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of patient’s body weight <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 14 days with at least <u>one preferred</u> drug 						
<p>Cardiovascular Agents: Angina, Hypertension & Heart Failure</p>	<p>LENGTH OF AUTHORIZATIONS: 365 days except nimodipine: 21 days</p> <p>PROPRANOLOL ORAL SOLUTION (HEMANGEOL) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of the patient’s weight <p>SACUBITRIL/VALSARTAN (ENTRESTO) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of chronic heart failure classified as either NYHA Class II-IV or ACC/AHA Stage B-D <p>ADDITIONAL FINERENONE (KERENDIA) CRITERIA:</p> <ul style="list-style-type: none"> • Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker • Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor OR provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis) <p>ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:</p> <ul style="list-style-type: none"> • Must be prescribed by or in consultation with a cardiologist • Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction $\geq 55\%$ <p>ADDITIONAL VERICIGUAT (VERQUVO) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of ejection fraction 						
<p>Cardiovascular Agents: Lipotropics</p>	<p>LENGTH OF AUTHORIZATIONS: See below</p> <table border="1" data-bbox="548 1383 1412 1497"> <tr> <td>Juxtapid (Initial)</td> <td>180 days</td> </tr> <tr> <td>Vascepa, Lovaza, ACL Inhibitors (Initial)</td> <td>84 days</td> </tr> <tr> <td>All others (Initial & Subsequent)</td> <td>365 days</td> </tr> </table> <p>ADDITIONAL LOVASTATIN ER (ALTOPREV), PITAVASTATIN (LIVALO), FLUVASTATIN (LESCOL) CRITERIA</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 30 days with <u>two preferred</u> drugs in the same drug class <p>ADDITIONAL ICOSAPENT ETHYL (VASCEPA) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of baseline labs indicating triglyceride levels $\geq 500\text{mg/dL}$ after an inadequate clinical response to fibrates, niacin, and diet/exercise 	Juxtapid (Initial)	180 days	Vascepa, Lovaza, ACL Inhibitors (Initial)	84 days	All others (Initial & Subsequent)	365 days
Juxtapid (Initial)	180 days						
Vascepa, Lovaza, ACL Inhibitors (Initial)	84 days						
All others (Initial & Subsequent)	365 days						



	<ul style="list-style-type: none"> Must provide documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate
Cardiovascular Agents: Pulmonary Arterial Hypertension*	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none"> Must provide documentation of NYHA Functional Class for Pulmonary Hypertension and symptoms experienced by patient
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>14 days</u> with <u>at least two preferred drugs</u> <p>ADDITIONAL UBROGEPANT (UBRELVY) CRITERIA</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred oral CGRP antagonist</u>
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>60 days</u> to at least <u>one preferred drug</u>
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none"> Must include objective documentation of severity, frequency, <u>type of migraine</u>, and number of headache days per month (preferably a headache diary) <p>SUBSEQUENT AUTHORIZATION CRITERIA:</p> <ul style="list-style-type: none"> Must provide documentation of patient’s clinical response to treatment (preferably a headache diary or other objective documentation of severity, frequency, and number of headache days per month). <p>QL – Aimovig, Emgality, Ajovy: 1 dose per 30 days</p>
Central Nervous System (CNS) Agents: Anticonvulsants*	<p>GRANDFATHERING* (except Epidolex and Diacomit): Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.</p> <p>CANNABIDIOL (EPIDIOLEX) CRITERIA</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>30 days</u> with any <u>two</u> of the following anticonvulsants: clobazam, levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide, or felbamate within the past 365 days (members who meet this criteria will not require a PA)



	<ul style="list-style-type: none"> • Must have had an inadequate clinical response (inadequate seizure control or intolerance) of at least 30 days with three preferred anticonvulsant drugs (Note: not required for Dravet Syndrome) • Must provide documentation of serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy • Must provide documentation of patient’s weight <ul style="list-style-type: none"> ◦ Maximum daily dose does not exceed: 20mg/kg/day for Lennox-Gastaut syndrome or Dravet syndrome or 25mg/kg/day for Tuberous sclerosis complex (titration based on response/tolerability) • Must provide baseline average number of seizure days per month (measured monthly or quarterly)
<p>Central Nervous System (CNS) Agents: Anticonvulsants Rescue</p>	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response with at least <u>one</u> preferred drug
<p>Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents</p>	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least <u>30</u> days with atomoxetine OR at least <u>two</u> preferred stimulants <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least <u>30</u> days with at least <u>three</u> preferred drugs <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> • Requests for non-preferred immediate-release formulations must have all required trials with preferred immediate-release drugs, and requests for non-preferred extended-release formulations must have all required trials with preferred extended-release drugs <p>AR – Dextroamphetamine Solution & Dyanavel XR: a PA is required for patients <u>12 years and older</u></p> <p>AR – Methylphenidate solution/suspension: a PA is required for patients younger than 6 years and 12 years and older</p>
<p>Central Nervous System (CNS) Agents: Atypical Antipsychotics*</p>	<p>ADDITIONAL ARIPIPRAZOLE (ABILIFY MYCITE) CRITERIA:</p> <ul style="list-style-type: none"> • Must be prescribed by <u>or in consultation with</u> a psychiatrist following an aripiprazole serum blood level draw indicating need for further investigation of adherence <p>ADDITIONAL PIMAVANSERIN (NUPLAZID) CRITERIA:</p> <ul style="list-style-type: none"> • For Parkinson-related Hallucinations & Delusions ALL of the following must be met:



	<ul style="list-style-type: none"> ○ Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic AND are not related to dementia or delirium ○ The patient’s other Parkinson’s Disease drugs have been reduced or adjusted and psychotic symptoms persist OR patient is unable to tolerate adjustment of these other drugs ○ Must have been inadequate clinical response or contraindication to at least <u>30 days</u> of either quetiapine or clozapine <ul style="list-style-type: none"> ● An exemption to the criteria will be authorized for prescribers with a neurology specialty to a patient with a history of the related condition <p><u>ADDITIONAL FLUOXETINE/OLANZAPINE (SYMBYAX) CRITERIA</u></p> <ul style="list-style-type: none"> ● Must provide documentation for patient’s inability to use the individual drugs
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	<p><u>LENGTH OF AUTHORIZATIONS:</u> 180 days except 14 days for Lucemyra</p> <p><u>NON-PREFERRED CRITERIA:</u></p> <ul style="list-style-type: none"> ● Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>two preferred</u> drugs
Central Nervous System (CNS) Agents: Movement Disorders	<p><u>CLINICAL PA CRITERIA:</u></p> <ul style="list-style-type: none"> ● Must be prescribed by or in consultation with a neurologist or psychiatrist <p><u>STEP THERAPY CRITERIA:</u></p> <ul style="list-style-type: none"> ● Must have an inadequate clinical response of at least <u>90 days</u> to a maximally tolerated dose of tetrabenazine for <u>Huntington’s Disease only</u> <p><u>NON-PREFERRED CRITERIA:</u></p> <ul style="list-style-type: none"> ● Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>two preferred</u> drugs
Central Nervous System (CNS) Agents: Narcolepsy	AR – Methylphenidate: a PA is required for patients younger than 6 years
Endocrine Agents: Androgens	<p><u>SUBSEQUENT AUTHORIZATION CRITERIA:</u></p> <ul style="list-style-type: none"> ● Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring (<u>i.e., testosterone and hematocrit</u>)
Endocrine Agents: Diabetes – Insulin	<u>STEP THERAPY CRITERIA:</u>



	<ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>120 days</u> with at least <u>one preferred drug</u> having a similar duration of action <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>120 days</u> with at least <u>two preferred drugs</u> having a similar duration of action
Endocrine Agents: Diabetes – Non-Insulin	<p>ADDITIONAL ORAL AND INJECTABLE COMBINATION DRUGS CRITERIA</p> <ul style="list-style-type: none"> Must have had a trial of at least <u>120 days</u> with the individual drugs OR must provide documentation of medical necessity beyond convenience for patient’s inability to use the individual drugs <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least <u>one inadequate clinical response</u> with a drug in same drug class
Endocrine Agents: Endometriosis	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>84 days</u> with at least <u>one preferred NSAID</u>, <u>one preferred oral contraceptive</u>, AND <u>one preferred step-therapy drug</u>
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least <u>365 days</u> with at least <u>one preferred drug</u> within the same class <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> A total lifetime duration of therapy of 730 days with <u>any parathyroid analog</u> will be authorized
Endocrine Agents: Uterine Fibroids	<p>LENGTH OF AUTHORIZATIONS: <u>Up to 180 Days</u></p> <p>ADDITIONAL INFORMATION:</p> <ul style="list-style-type: none"> A total lifetime duration of therapy of <u>730 days</u> <u>between Oriahnn and Myfembree</u> or 180 days for Lupron Depot will be authorized
Gastrointestinal Agents: Crohn’s Disease	<p>LENGTH OF AUTHORIZATIONS: 365 Days; <u>Ortikos ER – based on indication</u></p>
Gastrointestinal Agents: Hepatic Encephalopathy	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of <u>at least 14 days</u> with at least <u>one preferred drug</u>



	<p><u>RIFAXAMIN (XIFAXAN) CRITERIA:</u></p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 14 days to lactulose to be authorized for monotherapy or add on therapy <p><u>NON-PREFERRED CRITERIA:</u></p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
<p>Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea</p>	<p><u>STEP THERAPY CRITERIA:</u></p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 30 days with at least one preferred drug <p><u>NON-PREFERRED CRITERIA:</u></p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
<p>Gastrointestinal Agents: Proton Pump Inhibitors</p>	<p><u>ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY</u></p> <ul style="list-style-type: none"> For any of the following diagnoses: carcinoma of GI tract, COPD, Crest Syndrome, dyspepsia, esophageal varices, gastritis, gastroparesis, scleroderma, symptomatic uncomplicated Barret’s Esophagus, systemic mastocytosis, or Zollinger Ellison Syndrome: Must provide documentation of diagnosis AND must have failed once-daily dosing of the requested drug <ul style="list-style-type: none"> Authorization length: 365 days <p>AR - Protonix Pak/Pantoprazole Packet: a PA is required for patients 6 years and older</p>
<p>Gastrointestinal Agents: Ulcerative Colitis</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> 365 Days; except Uceris foam – based on indication</p>
<p>Gastrointestinal Agents: Unspecified GI</p>	<p><u>ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:</u></p> <ul style="list-style-type: none"> Must have the inability to take, or failure of ALL of the following: azithromycin, ciprofloxacin, levofloxacin, ofloxacin, or rifaximin
<p>Genitourinary Agents: Benign Prostatic Hyperplasia</p>	<p><u>ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) CRITERIA</u></p> <ul style="list-style-type: none"> Must provide documentation for patient’s inability to use the individual drugs
<p>Immunomodulator Agents: Systemic Inflammatory Disease</p>	<p><u>ADDITIONAL ALOPECIA AREATA CRITERIA:</u></p> <ul style="list-style-type: none"> Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist) Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid



	<p><u>ADDITIONAL ATOPIC DERMATITIS CRITERIA:</u></p> <ul style="list-style-type: none">• Must have at least 10% body surface area (BSA) involvement with <u>two</u> of the following: topical corticosteroid, <u>or</u> topical calcineurin inhibitors [e.g., Elidel], <u>or</u> topical PDE 4 inhibitors [e.g., Eucrisa] unless atopic dermatitis is severe and involves >25% BSA
<p>Infectious Disease Agents: Antibiotics – Cephalosporins</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> Based on indication</p> <p><u>ADDITIONAL INFORMATION</u></p> <ul style="list-style-type: none">• Requests may be authorized if:<ul style="list-style-type: none">○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, <u>only the remaining course will be authorized</u>
<p>Infectious Disease Agents: Antibiotics – Inhaled</p>	<p>QL – Tobramycin drugs: 56 doses in 56 days</p>
<p>Infectious Disease Agents: Antibiotics – Macrolides</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> Based on indication</p> <p><u>ADDITIONAL INFORMATION</u></p> <ul style="list-style-type: none">• Requests may be authorized if:<ul style="list-style-type: none">○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, <u>only the remaining course will be authorized</u>
<p>Infectious Disease Agents: Antibiotics – Quinolones</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> Based on indication</p> <p><u>ADDITIONAL INFORMATION</u></p> <ul style="list-style-type: none">• Requests may be authorized if:<ul style="list-style-type: none">○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, <u>only the remaining course will be authorized</u>
<p>Infectious Disease Agents: Antibiotics – Tetracyclines</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> Based on indication for acute infections or 365 days for acne</p> <p><u>NON-PREFERRED CRITERIA:</u></p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>one preferred</u> drug for acute infections OR at least <u>90 days</u> with at least <u>one preferred oral</u> drug for acne



	<p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> • Requests may be authorized if: <ul style="list-style-type: none"> ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized <p>AR – Doxycycline Syrup: a PA is required for patients 12 years and older</p>
<p>Infectious Disease Agents: Antifungals</p>	<p>LENGTH OF AUTHORIZATIONS: Based on indication</p> <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> • Requests may be authorized if: <ul style="list-style-type: none"> ○ The infection is caused by an organism resistant to ALL preferred antifungals (must provide diagnosis and any culture/sensitivity results) ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized ○ If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off-label use may be approvable for a medication such as Nizoral for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed
<p>Infectious Disease Agents: Antivirals – Hepatitis C Agents</p>	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response defined as not achieving SVR with guideline-recommended preferred drugs
<p>Infectious Disease Agents: Antivirals – HIV*</p>	<p>FOSTEMSAVIR (RUKOBIA ER) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of a multidrug resistant HIV 1 infection <p>ADDITIONAL DARUNAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR (SYMTUZA) CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation for patient's inability to use the individual drugs <p>AR – Lamivudine solution: a PA is required for patients 3 years and older</p> <p>AR – Nevirapine solution: a PA is required for patients 3 years and older</p>



<p>Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments</p>	<p>LENGTH OF AUTHORIZATIONS: 30 days</p> <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> • Requests may be authorized if: <ul style="list-style-type: none"> ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized
<p>Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers</p>	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
<p>Ophthalmic Agents: Dry Eye Treatments</p>	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 14 days with one artificial tear or OTC dry eye drop in the previous 120 days <p>NON-PREFERRED CRITERIA: Must have had an inadequate clinical response of at least 14 days with at least one preferred drug</p>
<p>Ophthalmic Agents: Glaucoma Agents</p>	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in the same class, if available <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
<p>Ophthalmic Agents: NSAIDs</p>	<p>LENGTH OF AUTHORIZATIONS: 30 days</p>
<p>Otic Agents: Antibacterial and Antibacterial/Steroid Combinations</p>	<p>LENGTH OF AUTHORIZATIONS: 30 days</p>
<p>Respiratory Agents: Antihistamines – Second Generation</p>	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 30 days with at least two different preferred drugs
<p>Respiratory Agents: Cystic Fibrosis</p>	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug <p>SUBSEQUENT AUTHORIZATION CRITERIA:</p> <ul style="list-style-type: none"> • Must provide documentation of patient’s clinical response to treatment (adherence to treatment demonstrated by claims



	history AND one or more of the following: FEV1, weight gain, sweat chloride, pulmonary exacerbations, etc.) and ongoing safety monitoring
Respiratory Agents: Hereditary Angioedema	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none"> Must provide documentation of diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment Must provide documentation of at-home administration <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 60 days with at least one preferred drug
Respiratory Agents: Inhaled Agents	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action
Respiratory Agents: Nasal Preparations	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
Respiratory Agents: Other Agents	<p>LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 180 days</p> <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 90 days with at least one preferred long-acting beta agonist AND one preferred long-acting muscarinic antagonist-containing inhalers <p>SUBSEQUENT AUTHORIZATION CRITERIA:</p> <ul style="list-style-type: none"> Must provide documentation of patient’s clinical response to treatment, adherence to maintenance inhaler per pharmacy claims, and ongoing safety monitoring
Topical Agents: Antifungals	<p>LENGTH OF AUTHORIZATIONS: Up to 180 days for all agents except 365 days for Jublia</p> <p>ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:</p> <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 365 days with at least one preferred topical drug AND at least 84 days with at least one preferred oral drug indicated for diagnosis <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none"> Requests may be authorized if:



	<ul style="list-style-type: none">○ The infection is caused by an organism resistant to preferred antibiotics drugs (note diagnosis and any culture/sensitivity results)
Topical Agents: Antiparasitics	<u>NON-PREFERRED CRITERIA:</u> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least 14 days with at least <u>one preferred</u> drug

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