2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Prior Authorization Policies can be accessed online at https://www.caresource.com/providers/tools-resources/health-partner-policies/pharmacy-policies/.			
Med Name	**Generic Name**	**Status**	**Criteria**
Abiraterone Acetate Tablet 250 MG Oral		Prior Authorization Required	*Initial Authorization*; *Diagnosis = Metastatic Prostate Cancer; *Prescriber Specialty = Oncology
Abstral TABLET SUBLINGUAL 100 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
Abstral TABLET SUBLINGUAL 200 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
Abstral TABLET SUBLINGUAL 300 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid

Abstral TABLET SUBLINGUAL 400 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
Abstral TABLET SUBLINGUAL 600 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
Abstral TABLET SUBLINGUAL 800 MCG SUBLINGUAL	FentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid

Acetaminophen-Codeine #2 Tablet 300-15 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Acetaminophen-Codeine #3 Tablet 300-30 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Acetaminophen-Codeine #4 Tablet 300-60 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Acetaminophen-Codeine Solution 120-12 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Acetaminophen-Codeine TABLET 300-15 MG ORAL		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Acetaminophen-Codeine Tablet 300-60 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Actemra ACTPen Solution Auto-Injector 162 MG/0.9ML Subcutaneous	Tocilizumab	Prior Authorization Required	*Follow The Acemtra Policy On CareSource.com
Actemra SOLUTION 200 MG/10ML Intravenous	Tocilizumab	Prior Authorization Required	*Follow The Acemtra Policy On CareSource.com
Actemra SOLUTION 400 MG/20ML Intravenous	Tocilizumab	Prior Authorization Required	*Follow The Acemtra Policy On CareSource.com
Actemra SOLUTION 80 MG/4ML Intravenous	Tocilizumab	Prior Authorization Required	*Follow The Acemtra Policy On CareSource.com
Actemra Solution Prefilled Syringe 162 MG/0.9ML Subcutaneous	Tocilizumab	Prior Authorization Required	*Follow The Acemtra Policy On CareSource.com
Actimmune Solution 2000000 UNIT/0.5ML Subcutaneous	Interferon Gamma-1B	Prior Authorization Required	*Diagnosis = Chronic Granulomatous Disease OR Malignant Osteoporosis
Acyclovir Cream 5 % External		Prior Authorization Required	*Diagnosis Of Cold Sores/Oral Herpes Simplex/ HSV-Type 1/Herpes Labialis AND *A 3 Day Trial Of: Docosanol (FDA Approved For Ages 12 & Older) [Will Still Accept Denavir As A Trial]; AND *A Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) Acyclovir 5% Ointment Cannot Be Used
Acyclovir Ointment 5 % External		Prior Authorization Required	*Diagnosis Of Acute Outbreak Of Genital Herpes Simplex/HSV-Type 2; OR *Diagnosis Of Cold Sores/Oral Herpes Simplex/HSV-Type 1/Herpes Labialis; AND *A 3 Day Trial Of Docosanol (FDA Approved Age 12 And Up) [Will Still Accept Denavir As A Trial]

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Adcetris SOLUTION RECONSTITUTED 50 MG Intravenous	Brentuximab Vedotin	Prior Authorization Required	*Diagnosis Of Anaplastic Large Cell Lymphoma (Systemic): Treatment Of Systemic Anaplastic Large Cell Lymphoma After Failure Of At Least 1 Prior Multi-Agent Chemotherapy Regimen; *OR* *Diagnosis Of Hodgkin Lymphoma, Relapsed Or Refractory: Treatment Of Classical Hodgkin Lymphoma After Failure Of At Least 2 Prior Multi-Agent Chemotherapy Regimens (In Patients Who Are Not Autologous Hematopoietic Stem Cell Transplant Candidates) Or After Failure Of Autologous Hematopoietic Stem Cell Transplant; *OR* *Diagnosis Of Hodgkin Lymphoma (Post-Autologous Hematopoietic Stem Cell Transplantation): Treatment (Maintenance Therapy) Of Classical Hodgkin Lymphoma In Patients At High Risk Of Relapse Or Progression As Post–Autologous Hematopoietic Stem Cell Transplant Consolidation
Adefovir Dipivoxil Tablet 10 MG Oral		Prior Authorization Required	*Age 12 Years And Older *Diagnosis Of Chronic Hepatitis B *Prescribed By Infectious Disease Specialist, Gastroenterologist, Hepatologist Or Transplant Physician
Adempas TABLET 0.5 MG ORAL	Riociguat	Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Adempas TABLET 1 MG ORAL	Riociguat	Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Adempas TABLET 1.5 MG ORAL	Riociguat	Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Adempas TABLET 2 MG ORAL	Riociguat	Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Adempas TABLET 2.5 MG ORAL	Riociguat	Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Afinitor Disperz TABLET SOLUBLE 2 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma

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Afinitor Disperz TABLET SOLUBLE 3 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma
Afinitor Disperz TABLET SOLUBLE 5 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma
Afinitor TABLET 10 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma
Afinitor TABLET 2.5 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma
Afinitor TABLET 5 MG ORAL	Everolimus	Prior Authorization Required	*Diagnosis Of Advanced Hormone Receptor–Positive, Human Epidermal Growth Receptor 2 (HER2)–Negative Breast Cancer, Advanced Neuroendocrine Tumors Of Pancreatic Origin, Advanced Renal Cell Carcinoma, Renal Angiomyolipoma And Tuberous Sclerosis Complex OR Adult And Pediatric Patients 3 Years And Older With Subependymal Giant Cell Astrocytoma
Albendazole Tablet 200 MG Oral		Prior Authorization Required	*Diagnosis Of Hydatid Disease OR Neurocysticercosis; *OR* *Diagnosis Of Enterobius Vermicularis (Pinworm) *AND* *30 Day Trial Of: Pin-X, Pamix 144 mg/mL (50 mg/mL) OTC Or Pinworm Tab Medicine 180 mg OTC
Alinia Suspension Reconstituted 100 MG/5ML Oral	Nitazoxanide	Prior Authorization Required	*Diagnosis of Diarrhea Caused By Giarda Lamblia OR Cryptosporidium Parvum
Alosetron HCl Tablet 0.5 MG Oral		Prior Authorization Required	*Diagnosis of Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) *7 Day Trial Of: Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)

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Alosetron HCl Tablet 1 MG Oral		Prior Authorization Required	*Diagnosis of Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) *7 Day Trial Of: Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)
Ambrisentan Tablet 10 MG Oral		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Ambrisentan Tablet 5 MG Oral		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Amitiza CAPSULE 24 MCG ORAL	Lubiprostone	Prior Authorization Required	*Age 18 Or Older; *Diagnosis Of Chronic Idiopathic Constipation (CIC) *AND* *Clinical Reason Of Why After A 90 Day Trial Cannot Continue On Trulance (Which Also Requires A PA) **OR** *Diagnosis Of Opioid-Induced Constipation (OIC) *AND* *7 Day Trial Supported By Pharmacy Claims Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
Aprepitant Capsule 125 MG Oral		Prior Authorization Required	*Age 12 Years Or Older *Diagnosis Of Prevention Of Nausea/Vomiting Associated With Moderate To High Emetogenic Chemotherapy *Used In Combination With Other Antiemetics (Example: A 5-HT3 Receptor Antagonist (Ondansetron, Granisetron, Palonosetron) And Corticosteroid For Adults And One Or Both In Members Under 18) *OR* *Diagnosis Of Prevention Of Post-Operative Nausea/Vomiting *Previous Trial/Failure With At Least One Of The Following: Promethazine, Ondansetron, Prochlorperazine, Scopolamine Transdermal Patch, Metoclopramide
Aprepitant CAPSULE 40 MG Oral		Prior Authorization Required	*Age 12 Years Or Older *Diagnosis Of Prevention Of Nausea/Vomiting Associated With Moderate To High Emetogenic Chemotherapy *Used In Combination With Other Antiemetics (Example: A 5-HT3 Receptor Antagonist (Ondansetron, Granisetron, Palonosetron) And Corticosteroid For Adults And One Or Both In Members Under 18) *OR* *Diagnosis Of Prevention Of Post-Operative Nausea/Vomiting *Previous Trial/Failure With At Least One Of The Following: Promethazine, Ondansetron, Prochlorperazine, Scopolamine Transdermal Patch, Metoclopramide

Aprepitant CAPSULE 80 & 125 MG Oral		Prior Authorization Required	*Age 12 Years Or Older *Diagnosis Of Prevention Of Nausea/Vomiting Associated With Moderate To High Emetogenic Chemotherapy *Used In Combination With Other Antiemetics (Example: A 5-HT3 Receptor Antagonist (Ondansetron, Granisetron, Palonosetron) And Corticosteroid For Adults And One Or Both In Members Under 18) *OR* *Diagnosis Of Prevention Of Post-Operative Nausea/Vomiting *Previous Trial/Failure With At Least One Of The Following: Promethazine, Ondansetron, Prochlorperazine, Scopolamine Transdermal Patch, Metoclopramide
Aprepitant CAPSULE 80 MG Oral		Prior Authorization Required	*Age 12 Years Or Older *Diagnosis Of Prevention Of Nausea/Vomiting Associated With Moderate To High Emetogenic Chemotherapy *Used In Combination With Other Antiemetics (Example: A 5-HT3 Receptor Antagonist (Ondansetron, Granisetron, Palonosetron) And Corticosteroid For Adults And One Or Both In Members Under 18) *OR* *Diagnosis Of Prevention Of Post-Operative Nausea/Vomiting *Previous Trial/Failure With At Least One Of The Following: Promethazine, Ondansetron, Prochlorperazine, Scopolamine Transdermal Patch, Metoclopramide
Aranesp (Albumin Free) SOLUTION 100 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 100 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 200 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 200 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 25 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com

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Aranesp (Albumin Free) SOLUTION 25 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 300 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 300 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 40 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 40 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 60 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) SOLUTION 60 MCG/ML INJECTION	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 10 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 10 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 100 MCG/0.5ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 100 MCG/0.5ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com

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Aranesp (Albumin Free) Solution Prefilled Syringe 150 MCG/0.3ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 150 MCG/0.3ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 200 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 200 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 25 MCG/0.42ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 25 MCG/0.42ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 300 MCG/0.6ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 300 MCG/0.6ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 40 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 40 MCG/0.4ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 500 MCG/ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com

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Aranesp (Albumin Free) Solution Prefilled Syringe 500 MCG/ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 60 MCG/0.3ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Aranesp (Albumin Free) Solution Prefilled Syringe 60 MCG/0.3ML Injection	Darbepoetin Alfa	Prior Authorization Required	*Follow The Aranesp Policy On CareSource.com
Armodafinil Tablet 150 MG Oral		Prior Authorization Required	*Diagnosis Of Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea; *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis Of Shift Work Disorder
Armodafinil TABLET 200 MG Oral		Prior Authorization Required	*Diagnosis Of Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea; *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis Of Shift Work Disorder
Armodafinil Tablet 250 MG Oral		Prior Authorization Required	*Diagnosis Of Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea; *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis Of Shift Work Disorder
Armodafinil Tablet 50 MG Oral		Prior Authorization Required	*Diagnosis Of Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea; *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis Of Shift Work Disorder

Ascomp-Codeine Capsule 50-325-40-30 MG Oral	Butalbital-ASA-Caff-Codeine	Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Austedo TABLET 12 MG Oral	Deutetrabenazine	Prior Authorization Required	*Follow The Austedo Policy On CareSource.com
Austedo TABLET 6 MG Oral	Deutetrabenazine	Prior Authorization Required	*Follow The Austedo Policy On CareSource.com
Austedo TABLET 9 MG Oral	Deutetrabenazine	Prior Authorization Required	*Follow The Austedo Policy On CareSource.com
Baraclude SOLUTION 0.05 MG/ML ORAL	Entecavir	Prior Authorization Required	*Diagnosis Of Chronic Hepatitis B AND *Prescribed By Infectious Disease Specialist, Gastroenterologist, Hepatologist Or Transplant Physician
Betamethasone Dipropionate Ointment 0.05 % External		Prior Authorization Required	*A 14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate 0.05% Augmented Cream (Diprolene AF), Betamethasone Dipropionate 0.05% Augmented Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema) Or Psoriasis; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Bexarotene Capsule 75 MG Oral		Prior Authorization Required	Diagnosis Of: Cutaneous T-Cell Lymphoma
Bosentan Tablet 125 MG Oral		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Bosentan Tablet 62.5 MG Oral		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Brilinta TABLET 60 MG ORAL	Ticagrelor	Prior Authorization Required	*30 Day Trial Of: Clopidogrel (Plavix)
Brilinta TABLET 90 MG ORAL	Ticagrelor	Prior Authorization Required	*30 Day Trial Of: Clopidogrel (Plavix)

Buprenorphine HCl TABLET SUBLINGUAL 2 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Buprenorphine HCl Tablet Sublingual 8 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Buprenorphine HCl-Naloxone HCl Film 12-3 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine

Buprenorphine HCl-Naloxone HCl Film 2-0.5 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Buprenorphine HCl-Naloxone HCl Film 4-1 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Buprenorphine HCl-Naloxone HCl Film 8-2 MG Sublingual		Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Suboxone (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine

Butalbital-APAP-Caff-Cod Capsule 50-325-40-30 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Butalbital-ASA-Caff-Codeine CAPSULE 50-325-40-30 MG ORAL		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Capecitabine Tablet 150 MG Oral		Prior Authorization Required	*Diagnosis = Colorectal, Colon Or Breast Cancer OR Adjuvant For Colon Cancer
Capecitabine Tablet 500 MG Oral		Prior Authorization Required	*Diagnosis = Colorectal, Colon Or Breast Cancer OR Adjuvant For Colon Cancer
Carbaglu TABLET 200 MG ORAL	Carglumic Acid	Prior Authorization Required	*Diagnosis = Hyperammonemia
Carimune NF Solution Reconstituted 12 GM Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Carimune NF Solution Reconstituted 6 GM Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Carisoprodol-Aspirin Tablet 200-325 MG Oral		Prior Authorization Required	*30 Day Trial Of: Carisoprodol 350 mg Tablet
Cayston Solution Reconstituted 75 MG Inhalation	Aztreonam Lysine	Prior Authorization Required	*Follow The Cayston Policy On CareSource.com
Celecoxib Capsule 100 MG Oral		Prior Authorization Required	*30 Day Trial Of Two Of The Following: Meloxicam, Diclofenac, Sulindac, Ketorolac OR *Age 60 Years And Older OR *Concurrent Use Of An Anticoagulant (Warfarin, Xarelto, Eliquis, Etc.)
Celecoxib Capsule 200 MG Oral		Prior Authorization Required	*30 Day Trial Of Two Of The Following: Meloxicam, Diclofenac, Sulindac, Ketorolac OR *Age 60 Years And Older OR *Concurrent Use Of An Anticoagulant (Warfarin, Xarelto, Eliquis, Etc.)
Celecoxib Capsule 400 MG Oral		Prior Authorization Required	*30 Day Trial Of Two Of The Following: Meloxicam, Diclofenac, Sulindac, Ketorolac OR *Age 60 Years And Older OR *Concurrent Use Of An Anticoagulant (Warfarin, Xarelto, Eliquis, Etc.)
Celecoxib Capsule 50 MG Oral		Prior Authorization Required	*30 Day Trial Of Two Of The Following: Meloxicam, Diclofenac, Sulindac, Ketorolac OR *Age 60 Years And Older OR *Concurrent Use Of An Anticoagulant (Warfarin, Xarelto, Eliquis, Etc.)

Cholbam CAPSULE 250 MG ORAL	Cholic Acid	Prior Authorization Required	*For Initial Auths* *Diagnosis = Bile Acid Synthesis Disorders Due To Single Enzyme Defects (SEDs=3β-HSD, AKR1D1, CTX, AMACR, CYP7A1, Smith-Lemli-Opitz) OR *Diagnosis = Peroxisomal Disorders (PDs) (Neonatal Adrenoleukodystropyhy, Generalized Peroxisomal Disorder, Refsum Disease, Zellweger Spectrum Disorders) Who Exhibit Manifestations Of Liver Disease, Steatorrhea Or Complications From Decreased Fat Soluble Vitamin Absorption *Prescriber Specialty = Hepatologist Or Pediatric Gastroenterologist
Cholbam CAPSULE 50 MG ORAL	Cholic Acid	Prior Authorization Required	*For Initial Auths* *Diagnosis = Bile Acid Synthesis Disorders Due To Single Enzyme Defects (SEDs=3β-HSD, AKR1D1, CTX, AMACR, CYP7A1, Smith-Lemli-Opitz) OR *Diagnosis = Peroxisomal Disorders (PDs) (Neonatal Adrenoleukodystropyhy, Generalized Peroxisomal Disorder, Refsum Disease, Zellweger Spectrum Disorders) Who Exhibit Manifestations Of Liver Disease, Steatorrhea Or Complications From Decreased Fat Soluble Vitamin Absorption *Prescriber Specialty = Hepatologist Or Pediatric Gastroenterologist
Cimzia KIT 2 X 200 MG Subcutaneous	Certolizumab Pegol	Prior Authorization Required	*Follow The Cimzia Policy On CareSource.com
Cimzia Prefilled KIT 2 X 200 MG/ML Subcutaneous	Certolizumab Pegol	Prior Authorization Required	*Follow The Cimzia Policy On CareSource.com
Cimzia Starter Kit KIT 6 X 200 MG/ML Subcutaneous	Certolizumab Pegol	Prior Authorization Required	*Follow The Cimzia Policy On CareSource.com
Climara Pro Patch Weekly 0.045-0.015 MG/DAY Transdermal	Estradiol-Levonorgestrel	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A Trial Of) *CombiPatch, Prempro, Premarin, Or Norethindrone Acetate-Ethinyl (FemHRT) Cannot Be Used
CloBAZam Suspension 2.5 MG/ML Oral		Prior Authorization Required	*Diagnosis = Seizure or Epilepsy *Trial Of 30 Days Trial Of 1 Of The Following: *Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
CloBAZam Tablet 10 MG Oral		Prior Authorization Required	*Diagnosis = Seizure or Epilepsy *Trial Of 30 Days Trial Of 1 Of The Following: *Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide

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CloBAZam Tablet 20 MG Oral		Prior Authorization Required	*Diagnosis = Seizure or Epilepsy *Trial Of 30 Days Trial Of 1 Of The Following: *Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Clobetasol Propionate Cream 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Clobetasol Propionate GEL 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Clobetasol Propionate Ointment 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology

Clobetasol Propionate Shampoo 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Clobetasol Propionate Solution 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology

Codeine Sulfate Tablet 30 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Codeine Sulfate Tablet 60 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Colchicine Tablet 0.6 MG Oral		Prior Authorization Required	*Diagnosis = Familial Mediterranean Fever OR *Diagnosis = Gout Or Pericarditis
Cometriq (100 mg Daily Dose) KIT 1 X 80 & 1 X 20 MG ORAL	Cabozantinib S-Malate	Prior Authorization Required	*Diagnosis = Progressive Metastatic Medullary Thyroid Cancer
Cosentyx 300 Dose Solution Prefilled Syringe 150 MG/ML Subcutaneous	Secukinumab	Prior Authorization Required	*Follow The Cosentyx Policy On CareSource.com
Cosentyx Sensoready 300 Dose Solution Auto-injector 150 MG/ML Subcutaneous	Secukinumab	Prior Authorization Required	*Follow The Cosentyx Policy On CareSource.com
Cosentyx Sensoready Pen Solution Auto-injector 150 MG/ML Subcutaneous	Secukinumab	Prior Authorization Required	*Follow The Cosentyx Policy On CareSource.com
Cosentyx Solution Prefilled Syringe 150 MG/ML Subcutaneous	Secukinumab	Prior Authorization Required	*Follow The Cosentyx Policy On CareSource.com
Cromolyn Sodium Concentrate 100 MG/5ML Oral		Prior Authorization Required	*Diagnosis = Mastocytosis AND *A Trial Of: Diphenhydramine (Benadryl)
Cuvitru SOLUTION 1 GM/5ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Cuvitru SOLUTION 2 GM/10ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Cuvitru SOLUTION 4 GM/20ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Cuvitru SOLUTION 8 GM/40ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Cuvposa SOLUTION 1 MG/5ML Oral	Glycopyrrolate	Prior Authorization Required	*Diagnosis = Drooling With Neurological Conditions Associated With Problem Drooling (Cerebral Palsy) Or Frey Syndrome *Age= 3-16 Years Of Age *Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Glycopyrrolate Tablet

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CVS Lansoprazole Capsule Delayed Release 15 MG Oral		Prior Authorization Required	*Clinical Reason Why OTC Lansoprazole/Prevacid Cannot Be Used After A 90 Day Trial Of OTC Formulation
Cytogam Injectable 50 MG/ML Intravenous	Cytomegalovirus Immune Glob	Prior Authorization Required	*Diagnosis = Seronegative Recipients Of Seropositive Organs May Receive Prophylaxis With CMV-IG If They Do Not Tolerate A Trial Of Antiviral Prophylaxis
Dalfampridine ER Tablet Extended Release 12 Hour 10 MG Oral		Prior Authorization Required	*Initial Auths* *Member Must Be Age 18 Or Older; AND *Medication Must Be Prescribed By, Or In Consultation With, Or Under The Guidance Of A Neurologist; AND *Member Has Been On A Disease Modifying Agent For At Least The Last 90 Days; AND *Member Is Ambulatory And Has Documented Baseline Of The Timed 25 Foot Walk (T25FW) Between 8 And 45 Seconds
Daliresp Tablet 500 MCG Oral	Roflumilast	Prior Authorization Required	*Diagnosis = Severe COPD With Chronic Bronchitis And History Of Exacerbations (Or Request States To Reduce Risk Of Exacerbations) WITH *30 Day Trial Each Of Two Of The Following Four Groups: 1) Breo/Dulera/Advair/ Fluticasone-Salmeterol (AirDuo) OR 2) Flovent/Pulmicort OR 3) Spiriva Respimat (Respimat Is Preferred) OR 4) Montelukast (Singulair)/Theophylline
Deferasirox Tablet Soluble 125 MG Oral		Prior Authorization Required	*Diagnosis = Chronic Iron Overload Due To Blood Transfusions *Age= 2 Years And Older OR *Diagnosis = Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes *Age= 10 Years And Older *Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) *Serum Ferritin Greater Than 300 mcg/L *Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min *Does Not Have A Diagnosis Of MDS *Platelet Count >50 x 109/L
Deferasirox Tablet Soluble 250 MG Oral		Prior Authorization Required	*Diagnosis = Chronic Iron Overload Due To Blood Transfusions *Age= 2 Years And Older OR *Diagnosis = Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes *Age= 10 Years And Older *Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) *Serum Ferritin Greater Than 300 mcg/L *Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min *Does Not Have A Diagnosis Of MDS *Platelet Count >50 x 109/L

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Deferasirox Tablet Soluble 500 MG Oral		Prior Authorization Required	*Diagnosis = Chronic Iron Overload Due To Blood Transfusions *Age= 2 Years And Older OR *Diagnosis = Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes *Age= 10 Years And Older *Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) *Serum Ferritin Greater Than 300 mcg/L *Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min *Does Not Have A Diagnosis Of MDS *Platelet Count >50 x 109/L
Demser Capsule 250 MG Oral	Metyrosine	Prior Authorization Required	*Diagnosis = Pheochromocytoma
Denavir Cream 1 % External	Penciclovir	Prior Authorization Required	*Diagnosis = Cold Sores *3 Day Trial Of: Docosanol
Dexamethasone Sod Phosphate PF Solution 10 MG/ML Injection		Prior Authorization Required	*BILL TO MEDICAL BENEFIT*
Dexamethasone Sodium Phosphate SOLUTION 10 MG/ML INJECTION		Prior Authorization Required	*BILL TO MEDICAL BENEFIT*
Dexamethasone Sodium Phosphate Solution 120 MG/30ML Injection		Prior Authorization Required	*BILL TO MEDICAL BENEFIT*
Dexamethasone Sodium Phosphate Solution 20 MG/5ML Injection		Prior Authorization Required	*BILL TO MEDICAL BENEFIT*
Dexamethasone Sodium Phosphate Solution 4 MG/ML Injection		Prior Authorization Required	*BILL TO MEDICAL BENEFIT*

Diflorasone Diacetate CREAM 0.05 % EXTERNAL		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Diflorasone Diacetate Ointment 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Dipentum Capsule 250 MG Oral	Olsalazine Sodium	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Sulfasalazine Cannot Be Used
Dronabinol Capsule 10 MG Oral		Prior Authorization Required	*Diagnosis = Appetite Stimulation In AIDS Patients Or Cancer Chemotherapy-Induced Nausea And Vomiting *OR* *Diagnosis = Appetite Stimulation In Cystic Fibrosis IF Malnutrition/Decreased Food Intake Is Secondary To Loss Of Appetite WITH A 90 Day Trial Of One Of The Following: Cyproheptadine Or Megestrol
Dronabinol Capsule 2.5 MG Oral		Prior Authorization Required	*Diagnosis = Appetite Stimulation In AIDS Patients Or Cancer Chemotherapy-Induced Nausea And Vomiting *OR* *Diagnosis = Appetite Stimulation In Cystic Fibrosis IF Malnutrition/Decreased Food Intake Is Secondary To Loss Of Appetite WITH A 90 Day Trial Of One Of The Following: Cyproheptadine Or Megestrol
Dronabinol Capsule 5 MG Oral		Prior Authorization Required	*Diagnosis = Appetite Stimulation In AIDS Patients Or Cancer Chemotherapy-Induced Nausea And Vomiting *OR* *Diagnosis = Appetite Stimulation In Cystic Fibrosis IF Malnutrition/Decreased Food Intake Is Secondary To Loss Of Appetite WITH A 90 Day Trial Of One Of The Following: Cyproheptadine Or Megestrol

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Drospiren-Eth Estrad-Levomefol Tablet 3-0.02-0.451 MG Oral		Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Gianvi, Loryna, Or Vestura With Folic Acid Separately Taken Together Cannot Be Used
Droxia CAPSULE 200 MG ORAL	Hydroxyurea	Prior Authorization Required	*Diagnosis = Sickle Cell Anemia
Droxia CAPSULE 300 MG ORAL	Hydroxyurea	Prior Authorization Required	*Diagnosis = Sickle Cell Anemia
Droxia CAPSULE 400 MG ORAL	Hydroxyurea	Prior Authorization Required	*Diagnosis = Sickle Cell Anemia
Duavee TABLET 0.45-20 MG ORAL	Conj Estrogens-Bazedoxifene	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Combipatch, Prempro, Premarin, Or Norethindrone Acetate-Ethinyl (Femhrt) Cannot Be Used
Entecavir Tablet 0.5 MG Oral		Prior Authorization Required	*Diagnosis = Chronic Hepatitis B AND *Prescribed By Infectious Disease Specialist, Gastroenterologist, Hepatologist Or Transplant Physician
Entecavir Tablet 1 MG Oral		Prior Authorization Required	*Diagnosis = Chronic Hepatitis B AND *Prescribed By Infectious Disease Specialist, Gastroenterologist, Hepatologist Or Transplant Physician
Entresto Tablet 24-26 MG Oral	Sacubitril-Valsartan	Prior Authorization Required	*Diagnosis = Chronic Heart Failure (NYHA Class II-IV) And Reduced Ejection Fraction Of 40% Or Less AND *30 Day Trial Of: Ace Inhibitor (i.e. Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril) Or An ARB (i.e. Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)) OR Any Combination Drug That Contains One Of These Agents
Entresto Tablet 49-51 MG Oral	Sacubitril-Valsartan	Prior Authorization Required	*Diagnosis = Chronic Heart Failure (NYHA Class II-IV) And Reduced Ejection Fraction Of 40% Or Less AND *30 Day Trial Of: Ace Inhibitor (i.e. Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril) Or An ARB (i.e. Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)) OR Any Combination Drug That Contains One Of These Agents

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Entresto Tablet 97-103 MG Oral	Sacubitril-Valsartan	Prior Authorization Required	*Diagnosis = Chronic Heart Failure (NYHA Class II-IV) And Reduced Ejection Fraction Of 40% Or Less AND *30 Day Trial Of: Ace Inhibitor (i.e. Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril) Or An ARB (i.e. Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)) OR Any Combination Drug That Contains One Of These Agents
Epaned SOLUTION 1 MG/ML Oral	Enalapril Maleate	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) Enalapril Tablet Cannot Be Used
Epivir HBV SOLUTION 5 MG/ML ORAL	LamiVUDine	Prior Authorization Required	*Diagnosis = Chronic Hepatitis B AND *Prescribed By Infectious Disease Specialist, Gastroenterologist, Hepatologist Or Transplant Physician
Epoprostenol Sodium SOLUTION RECONSTITUTED 0.5 MG Intravenous		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Epoprostenol Sodium SOLUTION RECONSTITUTED 1.5 MG Intravenous		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
EQ Lansoprazole Capsule Delayed Release 15 MG Oral		Prior Authorization Required	*Clinical Reason Why OTC Lansoprazole/Prevacid Cannot Be Used After A 90 Day Trial Of OTC Formulation
Erlotinib HCl Tablet 100 MG Oral		Prior Authorization Required	Diagnosis = Pancreatic Cancer
Erlotinib HCl Tablet 150 MG Oral		Prior Authorization Required	Diagnosis = Non-Small Cell Lung Cancer
Erlotinib HCl Tablet 25 MG Oral		Prior Authorization Required	Diagnosis = Non-Small Cell Lung Cancer OR Pancreatic Cancer
Esbriet CAPSULE 267 MG ORAL	Pirfenidone	Prior Authorization Required	*Diagnosis = IPF (Idiopathic Pulmonary Fibrosis), Mild To Moderate In Severity *MD Specialty = Pulmonologist *Not A Current Smoker Or Are Receiving Smoking Cessation Treatment *Signs Of Disease Progression Exist (i.e Worsening Oxygenation, Worsening Lung Tomography, Pulmonary Hypertension, Pulmonary Embolism, Lung Cancer, Coronary Artery Disease)
Estradiol Tablet 10 MCG Vaginal		Prior Authorization Required	*Diagnosis = Atrophic Vaginitis AND *Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Estradiol Tablets, Estradiol Patches (Climara) Or Alora Cannot Be Used

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Evekeo ODT Tablet Dispersible 10 MG Oral	Amphetamine Sulfate	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Dextroamphetamine-Amphetamine (Adderall) Cannot Be Used
Evekeo ODT Tablet Dispersible 15 MG Oral	Amphetamine Sulfate	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Dextroamphetamine-Amphetamine (Adderall) Cannot Be Used
Evekeo ODT Tablet Dispersible 20 MG Oral	Amphetamine Sulfate	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Dextroamphetamine-Amphetamine (Adderall) Cannot Be Used
Evekeo ODT Tablet Dispersible 5 MG Oral	Amphetamine Sulfate	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Dextroamphetamine-Amphetamine (Adderall) Cannot Be Used
Extavia KIT 0.3 MG Subcutaneous	Interferon Beta-1b	Prior Authorization Required	*Follow The Extavia Policy On CareSource.com
Farydak Capsule 10 MG Oral	Panobinostat Lactate	Prior Authorization Required	*Diagnosis = Multiple Myeloma *Prescribed By Or Under The Consultation Of An Oncologist *Must Have Failed At Least 2 Previous Therapies *Must Be Used In Combination With Bortezomib (Velcade) Or Dexamethasone (Decadron)
Farydak Capsule 15 MG Oral	Panobinostat Lactate	Prior Authorization Required	*Diagnosis = Multiple Myeloma *Prescribed By Or Under The Consultation Of An Oncologist *Must Have Failed At Least 2 Previous Therapies *Must Be Used In Combination With Bortezomib (Velcade) Or Dexamethasone (Decadron)
Farydak Capsule 20 MG Oral	Panobinostat Lactate	Prior Authorization Required	*Diagnosis = Multiple Myeloma *Prescribed By Or Under The Consultation Of An Oncologist *Must Have Failed At Least 2 Previous Therapies *Must Be Used In Combination With Bortezomib (Velcade) Or Dexamethasone (Decadron)
FentaNYL Citrate Lozenge on a Handle 1200 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid

FentaNYL Citrate Lozenge On A Handle 1600 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
FentaNYL Citrate Lozenge On A Handle 200 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
FentaNYL Citrate Lozenge on a Handle 400 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
FentaNYL Citrate Lozenge on a Handle 600 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid

FentaNYL Citrate Lozenge on a Handle 800 MCG Buccal		Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid

FentaNYL Patch 72 Hour 100 MCG/HR Transdermal		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

fentaNYL Patch 72 Hour 12 MCG/HR Transdermal		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

FentaNYL Patch 72 Hour 25 MCG/HR Transdermal		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

FentaNYL Patch 72 Hour 50 MCG/HR Transdermal		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

FentaNYL Patch 72 Hour 75 MCG/HR Transdermal		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Fentora Tablet 600 MCG Buccal	fentaNYL Citrate	Prior Authorization Required	*Diagnosis = Cancer Related Pain; *Prescriber Specialty = Oncology, Palliative Care Specialist, Or Pain Specialist; *Member Is Currently Taking One Of The Following Long Acting Opioids For At Least 1 Week Without Adequate Pain Relief: A)Greater Than Or Equal To 60 mg Oral Morphine/Day; B)Greater Than Or Equal To 25 mcg/Hr Transdermal Fentanyl; C)Greater Than Or Equal To 30 mg Oral Oxycodone/Day; D)Greater Than Or Equal To 8 mg Oral Hydromorphone/Day; E)Greater Than Or Equal To 25 mg Oral Oxymorphone/Day; F)Equianalgesic Dose Of Another Opioid
Fluocinonide Cream 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Fluocinonide Gel 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology
Fluocinonide Ointment 0.05 % External		Prior Authorization Required	*14 Day Trial In The Last 120 Days Of One Of The Following: Betamethasone Dipropionate Augmented 0.05% Cream (Diprolene AF), Betamethasone Dipropionate Augmented 0.05% Lotion (Diprolene), Betamethasone Dipropionate 0.05% Cream Or Lotion, Desoximetasone 0.25% Cream (Topicort), Fluocinonide 0.05% Solution, Or Triamcinolone Acetonide 0.5% Cream Or Ointment; *OR* *Diagnosis Of Atopic Dermatitis (Extrinsic [Allergic], Intrinsic [Non-Allergic] Eczema), Psoriasis, Or Lichen Sclerosus; *OR* *Prescriber Specialty = Dermatology Or Rheumatology

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Fragmin SOLUTION 10000 UNIT/ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 12500 UNIT/0.5ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 15000 UNIT/0.6ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 18000 UNT/0.72ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 2500 UNIT/0.2ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 5000 UNIT/0.2ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
Fragmin SOLUTION 7500 UNIT/0.3ML Subcutaneous	Dalteparin Sodium	Prior Authorization Required	*Diagnosis = VTE/ Unstable Angina /Non-Q Wave MI AND *Unable To Take Oral Warfarin Or Enoxaparin (Lovenox) OR *Diagnosis = DVT AND *A One Time Trial Of: Enoxaparin (Lovenox)
GamaSTAN Injectable Intramuscular	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
GamaSTAN S/D Injectable Intramuscular	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard S/D Less IgA Solution Reconstituted 10 GM Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard S/D Less IgA Solution Reconstituted 5 GM Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard Solution 1 GM/10ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com

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Gammagard Solution 10 GM/100ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard Solution 2.5 GM/25ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard Solution 20 GM/200ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard Solution 30 GM/300ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammagard Solution 5 GM/50ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammaked Solution 10 GM/100ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammaked Solution 20 GM/200ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gammaked Solution 5 GM/50ML Injection	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 1 GM/10ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 10 GM/100ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 2.5 GM/25ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 20 GM/200ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 40 GM/400ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gamunex-C SOLUTION 5 GM/50ML INJECTION	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Gilenya CAPSULE 0.5 MG ORAL	Fingolimod HCl	Prior Authorization Required	*Follow The Gilenya Policy On CareSource.com

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Gilotrif TABLET 20 MG ORAL	Afatinib Dimaleate	Prior Authorization Required	*Diagnosis = Metastatic Non–Small Cell Lung Cancer *In Patients Whose Tumors Have Epidermal Growth Factor Receptor (EGFR) Exon 19 Deletions Or Exon 21 (L858R) Substitution Mutations As Detected By A Food And Drug Administration–Approved Test (MD Must Provide Test Results) OR *Diagnosis = Non-Small Cell Lung Cancer, Metastatic Squamous *Member Failed Platinum-Based Chemotherapy
Gilotrif TABLET 30 MG ORAL	Afatinib Dimaleate	Prior Authorization Required	*Diagnosis = Metastatic Non–Small Cell Lung Cancer *In Patients Whose Tumors Have Epidermal Growth Factor Receptor (EGFR) Exon 19 Deletions Or Exon 21 (L858R) Substitution Mutations As Detected By A Food And Drug Administration–Approved Test (MD Must Provide Test Results) OR *Diagnosis = Non-Small Cell Lung Cancer, Metastatic Squamous *Member Failed Platinum-Based Chemotherapy
Gilotrif TABLET 40 MG ORAL	Afatinib Dimaleate	Prior Authorization Required	*Diagnosis = Metastatic Non–Small Cell Lung Cancer *In Patients Whose Tumors Have Epidermal Growth Factor Receptor (EGFR) Exon 19 Deletions Or Exon 21 (L858R) Substitution Mutations As Detected By A Food And Drug Administration–Approved Test (MD Must Provide Test Results) OR *Diagnosis = Non-Small Cell Lung Cancer, Metastatic Squamous *Member Failed Platinum-Based Chemotherapy
GoodSense Lansoprazole Capsule Delayed Release 15 MG Oral		Prior Authorization Required	*Clinical Reason Why OTC Lansoprazole/Prevacid Cannot Be Used After A 90 Day Trial Of OTC Formulation
Grastek TABLET SUBLINGUAL 2800 BAU Sublingual	Timothy Grass Pollen Allergen	Prior Authorization Required	*Diagnosis = Skin Test Or In Vitro Testing For Pollen-Specific IgE Antibodies For Timothy Grass Or Cross-Reactive Grass Pollens
HepaGam B Solution Injection	Hepatitis B Immune Globulin	Prior Authorization Required	*Medical Benefit Only*
Hetlioz CAPSULE 20 MG ORAL	Tasimelteon	Prior Authorization Required	*Diagnosis = Non-24-Hour Sleep Wake Disorder AND Member Is Blind AND *90-Day Trial Each Of ALL Of The Following: Melatonin, Rozerem (Also Requires A PA) Within The Last Year
Hizentra Solution 1 GM/5ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hizentra Solution 10 GM/50ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com

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Hizentra Solution 2 GM/10ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hizentra Solution 4 GM/20ML Subcutaneous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
HumaLOG Solution Cartridge 100 UNIT/ML Subcutaneous	Insulin Lispro	Prior Authorization Required	*Clinical Reason Why (After A 30 Day Trial Of) *Insulin Lispro (Humalog) Kwikpen, Insulin Lispro (Humalog) Vial, Admelog Solostar, Or Admelog Vial Cannot Be Used
Hycamtin CAPSULE 0.25 MG Oral	Topotecan HCl	Prior Authorization Required	*Diagnosis = Relapsed Small Cell Lung Cancer
Hycamtin CAPSULE 1 MG Oral	Topotecan HCl	Prior Authorization Required	*Diagnosis = Relapsed Small Cell Lung Cancer

HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROcodone-Acetaminophen Solution 5-217 MG/10ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROcodone-Acetaminophen Solution 7.5-325 MG/15ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROcodone-Acetaminophen Tablet 10-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROcodone-Acetaminophen Tablet 5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROcodone-Acetaminophen Tablet 7.5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Hydrocodone-Ibuprofen Tablet 7.5-200 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROmorphone HCl Liquid 1 MG/ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROmorphone HCl SUPPOSITORY 3 MG Rectal		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROmorphone HCl Tablet 2 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROmorphone HCl Tablet 4 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

HYDROmorphone HCl Tablet 8 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Hyqvia KIT 10 GM/100ML Subcutaneous	Immune Globulin-Hyaluronidase	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hyqvia KIT 2.5 GM/25ML Subcutaneous	Immune Globulin-Hyaluronidase	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hyqvia KIT 20 GM/200ML Subcutaneous	Immune Globulin-Hyaluronidase	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hyqvia KIT 30 GM/300ML Subcutaneous	Immune Globulin-Hyaluronidase	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Hyqvia KIT 5 GM/50ML Subcutaneous	Immune Globulin-Hyaluronidase	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Ibrance CAPSULE 100 MG ORAL	Palbociclib	Prior Authorization Required	*Diagnosis = Hormone Receptor (HR) - Positive, Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Advanced Or Metastatic Breast Cancer In Combination With The Following: Aromatase Inhibitor (Anastrazole, Letrozole, Or Exemestane) Or Fulvestrant
Ibrance CAPSULE 125 MG ORAL	Palbociclib	Prior Authorization Required	*Diagnosis = Hormone Receptor (HR) - Positive, Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Advanced Or Metastatic Breast Cancer In Combination With The Following: Aromatase Inhibitor (Anastrazole, Letrozole, Or Exemestane) Or Fulvestrant
Ibrance CAPSULE 75 MG ORAL	Palbociclib	Prior Authorization Required	*Diagnosis = Hormone Receptor (HR) - Positive, Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Advanced Or Metastatic Breast Cancer In Combination With The Following: Aromatase Inhibitor (Anastrazole, Letrozole, Or Exemestane) Or Fulvestrant
Iclusig Tablet 15 MG Oral	Ponatinib HCl	Prior Authorization Required	*Diagnosis = Philadelphia Chromosome–Positive Acute Lymphoblastic Leukemia (Ph+ALL) OR *Diagnosis = Chronic Phase, Accelerated Phase, Or Blast Phase Chronic Myeloid Leukemia (CML) With T3151 Mutation With Resistance Or Intolerance To Prior Therapy (Gleevec, Sprycel, Or Tasigna)
Iclusig Tablet 45 MG Oral	Ponatinib HCl	Prior Authorization Required	*Diagnosis = Philadelphia Chromosome–Positive Acute Lymphoblastic Leukemia (Ph+ALL) OR *Diagnosis = Chronic Phase, Accelerated Phase, Or Blast Phase Chronic Myeloid Leukemia (CML) With T3151 Mutation With Resistance Or Intolerance To Prior Therapy (Gleevec, Sprycel, Or Tasigna)
Idelvion Solution Reconstituted 3500 UNIT Intravenous	Coagulation Factor IX (rIX-FP)	Prior Authorization Required	*Medical Benefit Only *Follow The Antihemophilic Agents Policy On CareSource.com

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Imatinib Mesylate Tablet 100 MG Oral		Prior Authorization Required	*Diagnosis = Acute Lymphoblastic Leukemia; Aggressive Systemic Mastocytosis; Chronic Myeloid Leukemia; Dermatofibrosarcoma Protuberans; GI Stromal Tumors; Hypereosinophilic Syndrome And/Or Chronic Eosinophilic Leukemia; Or Myelodysplastic/Myeloproliferative Diseases
Imatinib Mesylate Tablet 400 MG Oral		Prior Authorization Required	*Diagnosis = Acute Lymphoblastic Leukemia; Aggressive Systemic Mastocytosis; Chronic Myeloid Leukemia; Dermatofibrosarcoma Protuberans; GI Stromal Tumors; Hypereosinophilic Syndrome And/Or Chronic Eosinophilic Leukemia; Or Myelodysplastic/Myeloproliferative Diseases
Increlex SOLUTION 40 MG/4ML Subcutaneous	Mecasermin	Prior Authorization Required	*Diagnosis = Growth Failure In Children With Severe Primary IGF-1 Deficiency (Must Provide *Height Standard Deviation Score, *Basal IGF-1 Standard Deviation Score, *Presence Of Neutralizing Antibodies To Growth Hormone) *MD Specialty Is Pediatric Endocrinologist Or Under The Recommendation Of A Pediatric Endocrinologist *OR* *Diagnosis Of Growth Hormone Deletion (Must Provide *Presence Of Neutralizing Antibodies To Growth Hormone) *MD Specialty Is Pediatric Endocrinologist Or Under The Recommendation Of A Pediatric Endocrinologist
Inlyta TABLET 1 MG ORAL	Axitinib	Prior Authorization Required	*Diagnosis = Advanced Renal Cell Cancer Or Cancer (Neoplasm) Of Kidney *MD Specialty = Oncology
Inlyta TABLET 5 MG ORAL	Axitinib	Prior Authorization Required	*Diagnosis = Advanced Renal Cell Cancer Or Cancer (Neoplasm) Of Kidney *MD Specialty = Oncology
Intron A SOLUTION 10000000 UNIT/ML INJECTION	Interferon Alfa-2B	Prior Authorization Required	*Follow The Pegylated And Non-Pegylated Interferon Policy On Caresource.com
Intron A SOLUTION 6000000 UNIT/ML INJECTION	Interferon Alfa-2B	Prior Authorization Required	*Follow The Pegylated And Non-Pegylated Interferon Policy On Caresource.com
Intron A SOLUTION RECONSTITUTED 10000000 UNIT Injection	Interferon Alfa-2B	Prior Authorization Required	*Follow The Pegylated And Non-Pegylated Interferon Policy On Caresource.com
Intron A SOLUTION RECONSTITUTED 18000000 UNIT Injection	Interferon Alfa-2B	Prior Authorization Required	*Follow The Pegylated And Non-Pegylated Interferon Policy On Caresource.com

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Intron A SOLUTION RECONSTITUTED 50000000 UNIT Injection	Interferon Alfa-2B	Prior Authorization Required	*Follow The Pegylated And Non-Pegylated Interferon Policy On Caresource.com
Invokamet TABLET 150-1000 MG ORAL	Canagliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Invokamet TABLET 150-500 MG ORAL	Canagliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Invokamet TABLET 50-1000 MG ORAL	Canagliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Invokamet TABLET 50-500 MG ORAL	Canagliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Invokana TABLET 100 MG ORAL	Canagliflozin	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Invokana TABLET 300 MG ORAL	Canagliflozin	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) THEN *60 Day Trial Of: Steglatro Or Segluromet
Jakafi TABLET 10 MG ORAL	Ruxolitinib Phosphate	Prior Authorization Required	*Diagnosis Of Any Of The Following: *Intermediate Or High-Risk Myelofibrosis Indicated By International Prognostic Scoring System (IPSS) Score > 1 *Symptomatic Low Risk Myelofibrosis *Primary Post-Polycythemia Vera Myelofibrosis *Post-Essential Thrombocythemia Myelofibrosis OR *Diagnosis = Polycythemia Vera *Documented Intolerance To Hydroxyurea Or Inadequate Response To Hydroxyurea After A 3 Month Trial. Inadequate Response May Include No Change Or Worsening MPN-SAF TSS Score (1 Most Favorable, 10 Least Favorable), Increase Or No Change In Spleen Size, Absence Of CBC Improvement Including Absence Of Decrease In Hematocrit, White Blood Cell Count Or Hematocrit.

Jakafi TABLET 15 MG ORAL	Ruxolitinib Phosphate	Prior Authorization Required	*Diagnosis Of Any Of The Following: *Intermediate Or High-Risk Myelofibrosis Indicated By International Prognostic Scoring System (IPSS) Score > 1 *Symptomatic Low Risk Myelofibrosis *Primary Post-Polycythemia Vera Myelofibrosis *Post-Essential Thrombocythemia Myelofibrosis OR *Diagnosis = Polycythemia Vera *Documented Intolerance To Hydroxyurea Or Inadequate Response To Hydroxyurea After A 3 Month Trial. Inadequate Response May Include No Change Or Worsening MPN-SAF TSS Score (1 Most Favorable, 10 Least Favorable), Increase Or No Change In Spleen Size, Absence Of CBC Improvement Including Absence Of Decrease In Hematocrit, White Blood Cell Count Or Hematocrit.
Jakafi TABLET 20 MG ORAL	Ruxolitinib Phosphate	Prior Authorization Required	*Diagnosis Of Any Of The Following: *Intermediate Or High-Risk Myelofibrosis Indicated By International Prognostic Scoring System (IPSS) Score > 1 *Symptomatic Low Risk Myelofibrosis *Primary Post-Polycythemia Vera Myelofibrosis *Post-Essential Thrombocythemia Myelofibrosis OR *Diagnosis = Polycythemia Vera *Documented Intolerance To Hydroxyurea Or Inadequate Response To Hydroxyurea After A 3 Month Trial. Inadequate Response May Include No Change Or Worsening MPN-SAF TSS Score (1 Most Favorable, 10 Least Favorable), Increase Or No Change In Spleen Size, Absence Of CBC Improvement Including Absence Of Decrease In Hematocrit, White Blood Cell Count Or Hematocrit.
Jakafi TABLET 25 MG ORAL	Ruxolitinib Phosphate	Prior Authorization Required	*Diagnosis Of Any Of The Following: *Intermediate Or High-Risk Myelofibrosis Indicated By International Prognostic Scoring System (IPSS) Score > 1 *Symptomatic Low Risk Myelofibrosis *Primary Post-Polycythemia Vera Myelofibrosis *Post-Essential Thrombocythemia Myelofibrosis OR *Diagnosis = Polycythemia Vera *Documented Intolerance To Hydroxyurea Or Inadequate Response To Hydroxyurea After A 3 Month Trial. Inadequate Response May Include No Change Or Worsening MPN-SAF TSS Score (1 Most Favorable, 10 Least Favorable), Increase Or No Change In Spleen Size, Absence Of CBC Improvement Including Absence Of Decrease In Hematocrit, White Blood Cell Count Or Hematocrit.

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Jakafi TABLET 5 MG ORAL	Ruxolitinib Phosphate	Prior Authorization Required	*Diagnosis Of Any Of The Following: *Intermediate Or High-Risk Myelofibrosis Indicated By International Prognostic Scoring System (IPSS) Score > 1 *Symptomatic Low Risk Myelofibrosis *Primary Post-Polycythemia Vera Myelofibrosis *Post-Essential Thrombocythemia Myelofibrosis OR *Diagnosis = Polycythemia Vera *Documented Intolerance To Hydroxyurea Or Inadequate Response To Hydroxyurea After A 3 Month Trial. Inadequate Response May Include No Change Or Worsening MPN-SAF TSS Score (1 Most Favorable, 10 Least Favorable), Increase Or No Change In Spleen Size, Absence Of CBC Improvement Including Absence Of Decrease In Hematocrit, White Blood Cell Count Or Hematocrit.
Juxtapid CAPSULE 10 MG ORAL	Lomitapide Mesylate	Prior Authorization Required	*Follow The Biologic Cholesterol Agents Policy On CareSource.com

Kadian Capsule Extended Release 24 Hour 200 MG Oral	Morphine Sulfate ER	Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

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Kalydeco PACKET 50 MG ORAL	Ivacaftor	Prior Authorization Required	*Follow The Kalydeco Policy On Caresource.com
Kalydeco PACKET 75 MG ORAL	Ivacaftor	Prior Authorization Required	*Follow The Kalydeco Policy On Caresource.com
Kalydeco TABLET 150 MG ORAL	Ivacaftor	Prior Authorization Required	*Follow The Kalydeco Policy On Caresource.com
Kevzara Solution Auto-Injector 150 MG/1.14ML Subcutaneous	Sarilumab	Prior Authorization Required	*Follow The Kevzara Policy On CareSource.com
Kevzara Solution Auto-Injector 200 MG/1.14ML Subcutaneous	Sarilumab	Prior Authorization Required	*Follow The Kevzara Policy On CareSource.com
Kevzara Solution Prefilled Syringe 150 MG/1.14ML Subcutaneous	Sarilumab	Prior Authorization Required	*Follow The Kevzara Policy On CareSource.com
Kevzara Solution Prefilled Syringe 200 MG/1.14ML Subcutaneous	Sarilumab	Prior Authorization Required	*Follow The Kevzara Policy On CareSource.com
Kynamro Solution Prefilled Syringe 200 MG/ML Subcutaneous	Mipomersen Sodium	Prior Authorization Required	*Follow The Biologic Cholesterol Agents Policy On CareSource.com
Lansoprazole Capsule Delayed Release 15 MG Oral		Prior Authorization Required	*Clinical Reason Why OTC Lansoprazole/Prevacid Cannot Be Used After A 90 Day Trial Of OTC Formulation
Lansoprazole Capsule Delayed Release 30 MG Oral		Prior Authorization Required	*Clinical Reason Why OTC Lansoprazole/Prevacid Cannot Be Used After A 90 Day Trial Of OTC Formulation
Lenvima 10 MG Daily Dose Capsule Therapy Pack 10 MG Oral	Lenvatinib 10 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Lenvima 12 MG Daily Dose Capsule Therapy Pack 3 x 4 MG Oral	Lenvatinib 12 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor

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Lenvima 14 MG Daily Dose Capsule Therapy Pack 10 & 4 MG Oral	Lenvatinib 14 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Lenvima 20 MG Daily Dose Capsule Therapy Pack 2 x 10 MG Oral	Lenvatinib 20 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Lenvima 24 MG Daily Dose Capsule Therapy Pack 2 x 10 MG & 4 MG Oral	Lenvatinib 24 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Lenvima 4 MG Daily Dose Capsule Therapy Pack 4 MG Oral	Lenvatinib 4 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Lenvima 8 MG Daily Dose Capsule Therapy Pack 2 x 4 MG Oral	Lenvatinib 8 MG Daily Dose	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors OR Advanced Renal Cell Carcinoma OR GI Stromal Tumor
Letrozole Tablet 2.5 MG Oral		Prior Authorization Required	*Diagnosis = Breast Cancer
Leuprolide Acetate KIT 1 MG/0.2ML Injection		Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lidocaine-Hydrocortisone Ace Cream 3-0.5 % Rectal		Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Lidocaine 3% Cream AND Hydrocortisone 0.5% Cream Separately Used Together At The Same Time Cannot Be Used
Lithostat TABLET 250 MG ORAL	Acetohydroxamic Acid	Prior Authorization Required	*Diagnosis = Chronic Urea-Splitting Urinary Infection
Lupron Depot (1-Month) KIT 3.75 MG Intramuscular	Leuprolide Acetate	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lupron Depot (1-Month) KIT 7.5 MG Intramuscular	Leuprolide Acetate	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lupron Depot (3-Month) KIT 11.25 MG Intramuscular	Leuprolide Acetate (3 Month)	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lupron Depot (3-Month) KIT 22.5 MG Intramuscular	Leuprolide Acetate (3 Month)	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com

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Lupron Depot (4-Month) KIT 30 MG Intramuscular	Leuprolide Acetate (4 Month)	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lupron Depot (6-Month) KIT 45 MG Intramuscular	Leuprolide Acetate (6 Month)	Prior Authorization Required	*Follow The Lupron Depot Policy On CareSource.com
Lyrica Capsule 100 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 150 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 200 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica CAPSULE 225 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 25 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 300 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 50 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica Capsule 75 MG Oral	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella

Lyrica SOLUTION 20 MG/ML ORAL	Pregabalin	Prior Authorization Required	*Diagnosis = Partial Onset Seizures *OR* *Diagnosis = Neuropathic Pain Associated With Diabetic Peripheral Neuropathy And One Of The Following: 1) Previously approved for Lyrica in the past year and PA Recently Expired *OR* 2) 30 Day Trial Of And Inadequate Response Or Intolerance To One Of The Following: a) SNRI Antidepressant (ex. Duloxetine Or Venlafaxine) b) Tricyclic Antidepressant (Amitriptyline, Nortriptyline, Clomipramine, Desipramine) c) Gabapentin *OR* *Diagnosis = Post Herpetic Neuralgia And One Of The Following: a) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following Medications: a)Gabapentin, b) Lidocaine Patch (Lidoderm), c) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis = Neuropathic Pain Due To Spinal Cord Injury *Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* *Diagnosis = Central Neuropathic Pain Cause By Primary Lesion Or Dysfunction Of The Central Nervous System (Spinal Cord Or Brain) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) 30 Day Trial And Inadequate Response Or Intolerance To One Of The Following: a) Gabapentin, b) Tricyclic Antidepressant (Amitriptyline, Desipramine, Nortriptyline) *OR* *Diagnosis Of Clinical Diagnosis Of Fibromyalgia (ex. Based Upon Symptoms Of Widespread Pain, Typically Reported In The Muscles And Joints, Findings Of Multiple Tender Points In Characteristic Soft Tissue Locations, And Any Disorder That Would Otherwise Explain The Pain Have Been Excluded) And One Of The Following: 1) Previously Approved For Lyrica In The Past Year And PA Recently Expired *OR* 2) Meets All Of The Following: a) Symptoms Have Been Present For At Least 3 Months, b) 30 Day Trial Each And Inadequate Response Or Intolerance To Two Of The Following Medications: i) Gabapentin, ii) Tricyclic Antidepressants, iii) Cyclobenzaprine, iv) Fluoxetine Or Alternative SSRI (ex. Citalopram, Escitalopram, Paroxetine, Sertraline), v) Cymbalta, vi) Savella
Mavyret TABLET 100-40 MG Oral	Glecaprevir-Pibrentasvir	Prior Authorization Required	*Follow The Mavyret Policy On CareSource.com

Mekinist TABLET 0.5 MG ORAL	Trametinib Dimethyl Sulfoxide	Prior Authorization Required	*Diagnosis = Advanced Melanoma That Is Metastatic Or Unresectable (Stage III Or Stage IV) With BRAF V600E Or V600K Mutations Used As A Single Agent OR Concurrently With Tafinlar (Dabrafenib) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test, THxID™-BRAF Kit (Chart Notes Are Required) OR *Diagnosis = Metastatic Non-Small Cell Lung Cancer (NSCLC) With BRAF V600E Mutation Used Concurrently With Tafinlar (Dabrafenib) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test, THxID™-BRAF Kit (Chart Notes Are Required)
Mekinist TABLET 2 MG ORAL	Trametinib Dimethyl Sulfoxide	Prior Authorization Required	*Diagnosis = Advanced Melanoma That Is Metastatic Or Unresectable (Stage III Or Stage IV) With BRAF V600E Or V600K Mutations Used As A Single Agent OR Concurrently With Tafinlar (Dabrafenib) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test, THxID™-BRAF Kit (Chart Notes Are Required) OR *Diagnosis = Metastatic Non-Small Cell Lung Cancer (NSCLC) With BRAF V600E Mutation Used Concurrently With Tafinlar (Dabrafenib) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test, THxID™-BRAF Kit (Chart Notes Are Required)

Meperidine HCl Solution 50 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Meperidine HCl Tablet 100 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Meperidine HCl Tablet 50 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Methadone HCl Intensol Concentrate 10 MG/ML Oral	Methadone HCl	Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Methadone HCl SOLUTION 10 MG/5ML ORAL		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Methadone HCl SOLUTION 10 MG/ML Injection		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Methadone HCl SOLUTION 5 MG/5ML ORAL		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Methadone HCl Tablet 10 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Methadone HCl Tablet 5 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Metoprolol Tartrate Solution Cartridge 5 MG/5ML Intravenous		Prior Authorization Required	*Medical Benefit Only*
Miglustat Capsule 100 MG Oral		Prior Authorization Required	*Follow The Zavesca Policy On CareSource.com
Modafinil Tablet 100 MG Oral		Prior Authorization Required	*Diagnosis = Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis = Shift Work Disorder
Modafinil Tablet 200 MG Oral		Prior Authorization Required	*Diagnosis = Narcolepsy, Cataplexy *OR* *Diagnosis Of Obstructive Sleep Apnea *Documentation Of CPAP Or Mandibular Advancement Device (If Patient Cannot Use CPAP) *OR* *Diagnosis = Shift Work Disorder

Morphine Sulfate (Concentrate) Solution 20 MG/ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 100 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 20 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 30 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Capsule Extended Release 24 Hour 40 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 50 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 60 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER CAPSULE EXTENDED RELEASE 24 HOUR 80 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Tablet Extended Release 100 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Tablet Extended Release 15 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Tablet Extended Release 200 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Tablet Extended Release 30 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate ER Tablet Extended Release 60 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

Morphine Sulfate Solution 10 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate Solution 20 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate SUPPOSITORY 10 MG Rectal		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate SUPPOSITORY 20 MG Rectal		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate SUPPOSITORY 30 MG Rectal		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate SUPPOSITORY 5 MG Rectal		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate TABLET 15 MG ORAL		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Morphine Sulfate TABLET 30 MG ORAL		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Moxifloxacin HCl Solution 0.5 % Ophthalmic		Prior Authorization Required	*Diagnosis = Cataract Surgery Or Corneal Ulcer/Keratitis OR *Diagnosis = Conjunctivitis *One Time Trial Of: Ciprofloxacin Or Ofloxacin Ophthalmic
Moxifloxacin HCl Tablet 400 MG Oral		Prior Authorization Required	*One Time Trial Of: Ciprofloxacin Or Levofloxacin
Nebupent Solution Reconstituted 300 MG Inhalation	Pentamidine Isethionate	Prior Authorization Required	*Diagnosis = Pneumocystis Carinii Pneumonia (PCP) In High-Risk, HIV-Infected Patients
Neosalus Lotion External	Dermatological Products, Misc.	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin) - GPI For Lower Cost - 90650000004100 Or 90650000003700 Cannot Be Used
NexAVAR TABLET 200 MG ORAL	SORAfenib Tosylate	Prior Authorization Required	*Diagnosis = Renal (Kidney) Cell Carcinoma, Hepatocellular (Liver) Carcinoma, Thyroid Carcinoma, Or Progressive Differentiated Thyroid Cancer Refractory To Radioactive Iodine Treatment
Nymalize SOLUTION 60 MG/20ML ORAL	NiMODipine	Prior Authorization Required	*Diagnosis = Subarachnoid Hemorrhage (SAH) AND *Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Nimodipine (Nimotop) 30 mg Capsule Cannot Be Used
Octreotide Acetate SOLUTION 100 MCG/ML Injection		Prior Authorization Required	*Diagnosis = Acromegaly; Carcinoid Tumors; Vasoactive Intestinal Peptide Tumors (VIPomas)
Octreotide Acetate SOLUTION 1000 MCG/ML Injection		Prior Authorization Required	*Diagnosis = Acromegaly; Carcinoid Tumors; Vasoactive Intestinal Peptide Tumors (VIPomas)
Octreotide Acetate SOLUTION 200 MCG/ML Injection		Prior Authorization Required	*Diagnosis = Acromegaly; Carcinoid Tumors; Vasoactive Intestinal Peptide Tumors (VIPomas)
Octreotide Acetate SOLUTION 50 MCG/ML Injection		Prior Authorization Required	*Diagnosis = Acromegaly; Carcinoid Tumors; Vasoactive Intestinal Peptide Tumors (VIPomas)
Octreotide Acetate SOLUTION 500 MCG/ML Injection		Prior Authorization Required	*Diagnosis = Acromegaly; Carcinoid Tumors; Vasoactive Intestinal Peptide Tumors (VIPomas)

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Ofev CAPSULE 100 MG ORAL	Nintedanib Esylate	Prior Authorization Required	*Diagnosis = IPF *MD Specialty = Pulmonology *Non-Smoker Or On Smoking Cessation Treatment For At Least 3 Months *Signs Of Disease Progression Exist (i.e. Worsening Oxygenation, Worsening Lung Tomography, Pulmonary Hypertension, Pulmonary Embolism, Lung Cancer, Coronary Artery Disease)
Ofev CAPSULE 150 MG ORAL	Nintedanib Esylate	Prior Authorization Required	*Diagnosis = IPF *MD Specialty = Pulmonology *Non-Smoker Or On Smoking Cessation Treatment For At Least 3 Months *Signs Of Disease Progression Exist (i.e. Worsening Oxygenation, Worsening Lung Tomography, Pulmonary Hypertension, Pulmonary Embolism, Lung Cancer, Coronary Artery Disease)
Olumiant Tablet 2 MG Oral	Baricitinib	Prior Authorization Required	*Follow The Olumiant Policy On CareSource.com

OmniPod 5 Pack	Insulin Disposable Pump	Prior Authorization Required	*Criteria For Type 1: Must Meet All Of The Following* *Diagnosis = Type 1 Diabetes Mellitus AND Maintenance Therapy For At Least Six Months Involving At Least THREE Injections Of Insulin Per Day AND Glucose Self-Testing At Least THREE Times Per Day On Average During The Past Month AND High Risk For Preventable Complications Of Diabetes AND Individual (Or Caregiver) Is Capable Of Managing The Pump AND The Member Has ONE Of The Following Symptoms Or Conditions: a) Glycated Hemoglobin Level (HbA1c) Greater Than 7% *OR* b) A History Of Recurring Hypoglycemia *OR* c) A History Of Severe Glycemic Excursions *Criteria For Type 2: Must Meet All Of The Following* *Diagnosis = Type 2 Diabetes Mellitus AND *Prescribed By Or In Consultation With An Endocrinologist AND *Maintenance Therapy For At Least Six Months Involving At Least THREE Injections Of Insulin Per Day And DAILY Documented Adjustments Of Insulin Dosage AND *Glucose Self-Testing At Least THREE Times Per Day On Average During The Past Month AND *Individual (Or Caregiver) Is Capable Of Managing The Pump AND *The Member Has 4/5 Has The Following Symptoms Or Conditions: a) Documented Glycated Hemoglobin Level (HbA1c) Greater Than 7% Within The Past Month AND b) Documented History Of Recurring Hypoglycemia AND c) Documented Fluctuations In Blood Glucose Before Mealtime AND d) Documented Early Morning Increase In Fasting Blood Sugar (Exceeds 200 mg/dl) AND e) Documented Severe Glycemic Excursions *Reauthorization Criteria* Prescriber Attestation Of The Following: a) The Individual (Or Someone Assisting The Individual) Is Capable Of Managing The Pump And That The Desired Improvement In Metabolic Control Can Be Achieved b) There Is Objective Documented Evidence Of Improvement In Control Of Diabetes (Specific To Baseline Status Of Disease For Individual Patients)

OmniPod Starter KIT	Insulin Disposable Pump	Prior Authorization Required	*Criteria For Type 1: Must Meet All Of The Following* *Diagnosis = Type 1 Diabetes Mellitus AND Maintenance Therapy For At Least Six Months Involving At Least THREE Injections Of Insulin Per Day AND Glucose Self-Testing At Least THREE Times Per Day On Average During The Past Month AND High Risk For Preventable Complications Of Diabetes AND Individual (Or Caregiver) Is Capable Of Managing The Pump AND The Member Has ONE Of The Following Symptoms Or Conditions: a) Glycated Hemoglobin Level (HbA1c) Greater Than 7% *OR* b) A History Of Recurring Hypoglycemia *OR* c) A History Of Severe Glycemic Excursions *Criteria For Type 2: Must Meet All Of The Following* *Diagnosis = Type 2 Diabetes Mellitus AND *Prescribed By Or In Consultation With An Endocrinologist AND *Maintenance Therapy For At Least Six Months Involving At Least THREE Injections Of Insulin Per Day And DAILY Documented Adjustments Of Insulin Dosage AND *Glucose Self-Testing At Least THREE Times Per Day On Average During The Past Month AND *Individual (Or Caregiver) Is Capable Of Managing The Pump AND *The Member Has 4/5 Has The Following Symptoms Or Conditions: a) Documented Glycated Hemoglobin Level (HbA1c) Greater Than 7% Within The Past Month AND b) Documented History Of Recurring Hypoglycemia AND c) Documented Fluctuations In Blood Glucose Before Mealtime AND d) Documented Early Morning Increase In Fasting Blood Sugar (Exceeds 200 mg/dl) AND e) Documented Severe Glycemic Excursions *Reauthorization Criteria* Prescriber Attestation Of The Following: a) The Individual (Or Someone Assisting The Individual) Is Capable Of Managing The Pump And That The Desired Improvement In Metabolic Control Can Be Achieved b) There Is Objective Documented Evidence Of Improvement In Control Of Diabetes (Specific To Baseline Status Of Disease For Individual Patients)
Omnitrope SOLUTION RECONSTITUTED 5.8 MG Subcutaneous	Somatropin	Prior Authorization Required	*Follow The Omnitrope Policy On Caresource.com
Orilissa Tablet 150 MG Oral	Elagolix Sodium	Prior Authorization Required	*Follow The Orilissa Policy On Caresource.com
Orilissa Tablet 200 MG Oral	Elagolix Sodium	Prior Authorization Required	*Follow The Orilissa Policy On Caresource.com

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

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Orkambi TABLET 100-125 MG ORAL	Lumacaftor-Ivacaftor	Prior Authorization Required	*Follow The Orkambi Policy On Caresource.com
Orkambi TABLET 200-125 MG ORAL	Lumacaftor-Ivacaftor	Prior Authorization Required	*Follow The Orkambi Policy On Caresource.com
Oxandrolone Tablet 10 MG Oral		Prior Authorization Required	*Diagnosis = Bone Pain With Osteoporosis *OR* *Diagnosis = Protein Catabolism *OR* *Diagnosis = Need For Weight Gain AND *Trial Of: Megesterol
Oxandrolone Tablet 2.5 MG Oral		Prior Authorization Required	*Diagnosis = Bone Pain With Osteoporosis *OR* *Diagnosis = Protein Catabolism *OR* *Diagnosis = Need For Weight Gain AND *Trial Of: Megesterol
Oxtellar XR Tablet Extended Release 24 Hour 150 MG Oral	OXcarbazepine ER	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Oxcarbazepine (Trileptal) Cannot Be Used
Oxtellar XR Tablet Extended Release 24 Hour 300 MG Oral	OXcarbazepine ER	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Oxcarbazepine (Trileptal) Cannot Be Used
Oxtellar XR Tablet Extended Release 24 Hour 600 MG Oral	OXcarbazepine ER	Prior Authorization Required	*Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Oxcarbazepine (Trileptal) Cannot Be Used

OxyCODONE HCl Capsule 5 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Concentrate 100 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Solution 5 MG/5ML Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Tablet 10 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Tablet 15 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Tablet 20 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Tablet 30 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE HCl Tablet 5 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

OxyCODONE-Acetaminophen Tablet 10-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Oxycodone-Acetaminophen Tablet 2.5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

oxyCODONE-Acetaminophen Tablet 5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

oxyCODONE-Acetaminophen Tablet 7.5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Oxycodone-Aspirin Tablet 4.8355-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

oxyMORphone HCl ER Tablet Extended Release 12 Hour 10 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

oxyMORphone HCl ER Tablet Extended Release 12 Hour 15 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

oxyMORphone HCl ER Tablet Extended Release 12 Hour 20 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

oxyMORphone HCl ER Tablet Extended Release 12 Hour 30 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

OxyMORphone HCl ER Tablet Extended Release 12 Hour 40 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

oxyMORphone HCl ER Tablet Extended Release 12 Hour 5 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

oxyMORphone HCl ER Tablet Extended Release 12 Hour 7.5 MG Oral		Prior Authorization Required	**Initial Auths** 1. If Member Has One Of The Following Diagnoses, Approve For Up To 90 Days Maximum: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 2. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days-Prescriber attests to checking prescription drug monitoring program (PDMP) - OARRS (OH) -If Cumulative MED Is > 80 MED/day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable To Patient And There Is Rationale For Higher Dose -Prescriber Attests To Attest To A Patient Specific Treatment Plan (e.g., Assessment Of Pain And Function Scores, A Baseline Urine Drug Test, Plans For Random Urine Drug Screens, An Opioid Contract, Etc.) -If Member Is Being Treated Concurrently With Benzodiazepine, Prescriber Attests That The Benefit Outweighs The Risk Of Benzodiazepine Use **Reauth Criteria** 1. Chart Notes (Or PA Request) State The Benefit Of Continued Therapy Outweighing Risks To Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement In Function And/Or Quality Of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh 2. If Member Has One Of The Following Diagnoses, Approve As Requested Up To 6 Months: a) Active Cancer Treatment Of Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) 3. If Diagnosis Is Moderate To Severe Chronic Pain (Please List Specific Diagnosis Code In Notes): -Member Meets All Initial Criteria -If Member Has NOT Been On Opioid Therapy For ≥ 90 Days, Approve Up To 90 Days -If Member Has Been On Opioid Therapy For ≥ 90 Days: -Prescriber Attests To The Patient Being Reassessed For Addiction Risk Or Mental Health Concerns (e.g., Using Screening, Brief Intervention, And Referral To Treatment [SBIRT] Tools), Including Referral To An Addiction Medicine Specialist When Appropriate. Documentation May Need Submitted Upon Request

2019 Ohio Medicaid Drugs Requiring Prior Authorization List

07/01/2019 Edition

Oxytrol Patch Twice Weekly 3.9 MG/24HR Transdermal	Oxybutynin	Prior Authorization Required	*Gender Male *Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Oxybutynin Or Oxybutynin ER Cannot Be Used *OR* *Gender Female *Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Oxytrol For Women OTC 3.9 mg/24 HR Patch Cannot Be Used
Pegasys ProClick SOLUTION 180 MCG/0.5ML Subcutaneous	Peginterferon alfa-2a	Prior Authorization Required	*Follow The Pegylated and Non-Pegylated Interferon Policy On CareSource.com
Pegasys SOLUTION 180 MCG/0.5ML Subcutaneous	Peginterferon alfa-2a	Prior Authorization Required	*Follow The Pegylated and Non-Pegylated Interferon Policy On CareSource.com
Pegasys SOLUTION 180 MCG/ML Subcutaneous	Peginterferon alfa-2a	Prior Authorization Required	*Follow The Pegylated and Non-Pegylated Interferon Policy On CareSource.com
PegIntron KIT 50 MCG/0.5ML Subcutaneous	Peginterferon alfa-2b	Prior Authorization Required	*Follow The Pegylated and Non-Pegylated Interferon Policy On CareSource.com
Pentamidine Isethionate Solution Reconstituted 300 MG Injection		Prior Authorization Required	*Diagnosis = Pneumocystis Carinii Pneumonia (PCP) In High-Risk, HIV-Infected Patients
Pentasa Capsule Extended Release 250 MG Oral	Mesalamine ER	Prior Authorization Required	*Diagnosis = Crohn's Disease & Specifies Small Intestine OR *Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Mesalamine (Asacol HD), Apriso ER, Delzicol Cannot Be Used
Pentasa Capsule Extended Release 500 MG Oral	Mesalamine ER	Prior Authorization Required	*Diagnosis = Crohn's Disease & Specifies Small Intestine OR *Clinical Reason Supported By Chart Notes Why (After A Trial Of) *Mesalamine (Asacol HD), Apriso ER, Delzicol Cannot Be Used

Pentazocine-Naloxone HCl Tablet 50-0.5 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Pimecrolimus Cream 1 % External		Prior Authorization Required	*Diagnosis = Alopecia [Requires RPh Review] *OR* *Diagnosis = Atopic Dermatitis Or Eczema *7 Day Trial Of: Tacrolimus (Protopic) 0.1% Or 0.03% Ointment
Pioglitazone HCl-Glimepiride TABLET 30-2 MG ORAL		Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Pioglitazone HCl-Glimepiride TABLET 30-4 MG ORAL		Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Priftin Tablet 150 MG Oral	Rifapentine	Prior Authorization Required	*Diagnosis = Pulmonary Tuberculosis OR Treatment Of Latent Tuberculosis Infection Caused By Myobacterium Tuberculosis In Combination With Isoniazid In Patients 2 Years And Older Who Are At High Risk Of Progression To Tuberculosis Disease
Privigen Solution 10 GM/100ML Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Privigen SOLUTION 20 GM/200ML Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Privigen Solution 40 GM/400ML Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Privigen Solution 5 GM/50ML Intravenous	Immune Globulin (Human)	Prior Authorization Required	*Medical Benefit Only *Follow The Immune Globulin (IVIG) Policy On CareSource.com
Procrit SOLUTION 10000 UNIT/ML INJECTION	Epoetin Alfa	Prior Authorization Required	*Follow The Procrit Policy On CareSource.com
Procrit SOLUTION 10000 UNIT/ML INJECTION	Epoetin Alfa	Prior Authorization Required	*Follow The Procrit Policy On CareSource.com
Promacta TABLET 25 MG ORAL	Eltrombopag Olamine	Prior Authorization Required	*Follow The Promacta Policy On CareSource.com
Promacta TABLET 50 MG ORAL	Eltrombopag Olamine	Prior Authorization Required	*Follow The Promacta Policy On CareSource.com
Promacta TABLET 75 MG ORAL	Eltrombopag Olamine	Prior Authorization Required	*Follow The Promacta Policy On CareSource.com
Pulmozyme SOLUTION 1 MG/ML INHALATION	Dornase Alfa	Prior Authorization Required	*Follow Pulmozyme Policy On Caresource.com

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Ragwitek TABLET SUBLINGUAL 12 AMB A 1-U Sublingual	Short Ragweed Pollen Ext	Prior Authorization Required	*Diagnosis = Treatment Of Short Ragweed Pollen–Induced Allergic Rhinitis, With Or Without Conjunctivitis, Confirmed By Positive Skin Test Or In Vitro Testing For Pollen-Specific IgE Antibodies For Short Ragweed Pollen AND *18 To 65 Years Of Age
Rebetol SOLUTION 40 MG/ML ORAL	Ribavirin	Prior Authorization Required	*DN= *MD Specialty= *Previous Treatment= *Genotype= *HCV RNA Level= *Fibrosis Level= *Fibrosis Test Type= (Accepted Tests: Liver Biopsy, Or Elastography Only (FibroSCAN AND US Elastography Are Examples Of Elastography); Currently On Suboxone Or Similiar Medication (If Yes, Give Most Recent Paid Claim Date)= *Past Drug And/Or Alcohol Abuser= *Negative Urine Drug Screens/Dates= *Negative Urine Alcohol Screens/Dates= *Co-Infected With HIV (AIDS)/Post Liver Transplant/Liver Cancer Waiting for Transplant= *Negative Q80K =
Rebif Rebidose Solution Auto-Injector 22 MCG/0.5ML Subcutaneous	Interferon Beta-1a	Prior Authorization Required	*Follow The Rebif Policy On CareSource.com
Rebif Rebidose Solution Auto-Injector 44 MCG/0.5ML Subcutaneous	Interferon Beta-1a	Prior Authorization Required	*Follow The Rebif Policy On CareSource.com
Rebif Rebidose Titration Pack Solution Auto-injector 6X8.8 & 6X22 MCG Subcutaneous	Interferon Beta-1a	Prior Authorization Required	*Follow The Rebif Policy On CareSource.com
Rebif Solution Prefilled Syringe 22 MCG/0.5ML Subcutaneous	Interferon Beta-1a	Prior Authorization Required	*Follow The Rebif Policy On CareSource.com
Rebif Solution Prefilled Syringe 44 MCG/0.5ML Subcutaneous	Interferon Beta-1a	Prior Authorization Required	*Follow The Rebif Policy On CareSource.com
Regranex GEL 0.01 % EXTERNAL	Becaplermin	Prior Authorization Required	*Diagnosis = Diabetic Neuropathic Ulcers *Ulcers Extend Into Subcutaneous Tissue Or Beyond And Have Adequate Blood Supply (Can Be Documented On PA Form Or Chart Notes)

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Repatha Pushtronex System Solution Cartridge 420 MG/3.5ML Subcutaneous	Evolocumab with Infusor	Prior Authorization Required	*Follow The Biologic Cholesterol Agents Policy On CareSource.com
Repatha Solution Prefilled Syringe 140 MG/ML Subcutaneous	Evolocumab	Prior Authorization Required	*Follow The Biologic Cholesterol Agents Policy On CareSource.com
Repatha SureClick Solution Auto-Injector 140 MG/ML Subcutaneous	Evolocumab	Prior Authorization Required	*Follow The Biologic Cholesterol Agents Policy On CareSource.com
Ribavirin Capsule 200 MG Oral		Prior Authorization Required	*DN= *MD Specialty= *Previous Treatment= *Genotype= *HCV RNA Level= *Fibrosis Level= *Fibrosis Test Type= (Accepted Tests: Liver Biopsy, Or Elastography Only (FibroSCAN AND US Elastography Are Examples Of Elastography); Currently On Suboxone Or Similiar Medication (If Yes, Give Most Recent Paid Claim Date)= *Past Drug And/Or Alcohol Abuser= *Negative Urine Drug Screens/Dates= *Negative Urine Alcohol Screens/Dates= *Co-Infected With HIV (AIDS)/Post Liver Transplant/Liver Cancer Waiting for Transplant= *Negative Q80K =
Ribavirin Tablet 200 MG Oral		Prior Authorization Required	*DN= *MD Specialty= *Previous Treatment= *Genotype= *HCV RNA Level= *Fibrosis Level= *Fibrosis Test Type= (Accepted Tests: Liver Biopsy, Or Elastography Only (FibroSCAN AND US Elastography Are Examples Of Elastography); Currently On Suboxone Or Similiar Medication (If Yes, Give Most Recent Paid Claim Date)= *Past Drug And/Or Alcohol Abuser= *Negative Urine Drug Screens/Dates= *Negative Urine Alcohol Screens/Dates= *Co-Infected With HIV (AIDS)/Post Liver Transplant/Liver Cancer Waiting for Transplant= *Negative Q80K =
Riluzole TABLET 50 MG ORAL		Prior Authorization Required	*Diagnosis = Amyotrophic Lateral Sclerosis
Rituxan Solution 100 MG/10ML Intravenous	riTUXimab	Prior Authorization Required	*Follow The Rituxan Policy On CareSource.com For Diagnosis Of Follicular Lymphoma, Diffuse Large B-Cell Lymphoma, Or Chronic Lymphocytic Leukemia ONLY (Rituxan Specific Criteria For These Diagnoses Must Still Have Been Met.)

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Rituxan SOLUTION 500 MG/50ML Intravenous	RiTUXimab	Prior Authorization Required	*Follow The Rituxan Policy On CareSource.com For Diagnosis Of Follicular Lymphoma, Diffuse Large B-Cell Lymphoma, Or Chronic Lymphocytic Leukemia ONLY (Rituxan Specific Criteria For These Diagnoses Must Still Have Been Met.)
RomiDEPsin Solution Reconstituted 10 MG Intravenous		Prior Authorization Required	*Diagnosis = Cutaneous T-Cell Lymphoma (CTCL) OR Peripheral T-Cell Lymphoma (PTCL) *MD Specialty = Oncology
Rosuvastatin Calcium Tablet 10 MG Oral		Prior Authorization Required	*30 Day Trial Of One Of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin
Rosuvastatin Calcium Tablet 20 MG Oral		Prior Authorization Required	*30 Day Trial Of One Of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin
Rosuvastatin Calcium Tablet 40 MG Oral		Prior Authorization Required	*30 Day Trial Of One Of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin
Rosuvastatin Calcium Tablet 5 MG Oral		Prior Authorization Required	*30 Day Trial Of One Of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin
Saphris Tablet Sublingual 10 MG Sublingual	Asenapine Maleate	Prior Authorization Required	*Diagnosis = Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism; *60 Day Trial Of: Aripiprazole (Abilify)
Saphris TABLET SUBLINGUAL 2.5 MG SUBLINGUAL	Asenapine Maleate	Prior Authorization Required	*Diagnosis = Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism; *60 Day Trial Of: Aripiprazole (Abilify)
Saphris Tablet Sublingual 5 MG Sublingual	Asenapine Maleate	Prior Authorization Required	*Diagnosis = Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism; *60 Day Trial Of: Aripiprazole (Abilify)
Segluromet Tablet 2.5-1000 MG Oral	Ertugliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Segluromet Tablet 2.5-500 MG Oral	Ertugliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Segluromet Tablet 7.5-1000 MG Oral	Ertugliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Segluromet Tablet 7.5-500 MG Oral	Ertugliflozin-Metformin HCl	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Selzentry SOLUTION 20 MG/ML Oral	Maraviroc	Prior Authorization Required	*Diagnosis = CCR5-TropicHIV-1 Infection *CCR5-Ropic Virus Verified By Trophile Or Other Validated Assay For Determining HIV Tropism
Selzentry Tablet 150 MG Oral	Maraviroc	Prior Authorization Required	*Diagnosis = CCR5-TropicHIV-1 Infection *CCR5-Ropic Virus Verified By Trophile Or Other Validated Assay For Determining HIV Tropism

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Selzentry TABLET 25 MG Oral	Maraviroc	Prior Authorization Required	*Diagnosis = CCR5-TropicHIV-1 Infection *CCR5-Ropic Virus Verified By Trophile Or Other Validated Assay For Determining HIV Tropism
Selzentry Tablet 300 MG Oral	Maraviroc	Prior Authorization Required	*Diagnosis = CCR5-TropicHIV-1 Infection *CCR5-Ropic Virus Verified By Trophile Or Other Validated Assay For Determining HIV Tropism
Selzentry TABLET 75 MG Oral	Maraviroc	Prior Authorization Required	*Diagnosis = CCR5-TropicHIV-1 Infection *CCR5-Ropic Virus Verified By Trophile Or Other Validated Assay For Determining HIV Tropism
Sildenafil Citrate Tablet 20 MG Oral		Prior Authorization Required	*Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Siliq Solution Prefilled Syringe 210 MG/1.5ML Subcutaneous	Brodalumab	Prior Authorization Required	*Follow The Siliq Policy On CareSource.com
Sodium Phenylbutyrate POWDER 3 GM/TSP Oral		Prior Authorization Required	*Diagnosis = Urea Cycle Disorders
Sodium Phenylbutyrate TABLET 500 MG Oral		Prior Authorization Required	*Diagnosis = Urea Cycle Disorders
Soliqua Solution Pen-injector 100-33 UNT-MCG/ML Subcutaneous	Insulin Glargine-Lixisenatide	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Somavert SOLUTION RECONSTITUTED 10 MG Subcutaneous	Pegvisomant	Prior Authorization Required	Request Must Go Through Clinical Review
Somavert SOLUTION RECONSTITUTED 15 MG Subcutaneous	Pegvisomant	Prior Authorization Required	Request Must Go Through Clinical Review
Somavert SOLUTION RECONSTITUTED 20 MG Subcutaneous	Pegvisomant	Prior Authorization Required	Request Must Go Through Clinical Review
Somavert SOLUTION RECONSTITUTED 25 MG Subcutaneous	Pegvisomant	Prior Authorization Required	Request Must Go Through Clinical Review
Somavert SOLUTION RECONSTITUTED 30 MG Subcutaneous	Pegvisomant	Prior Authorization Required	Request Must Go Through Clinical Review

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Spinosad Suspension 0.9 % External		Prior Authorization Required	*Diagnosis = Head Lice *One time trial And Failure Of Malathion, OTC Permethrin, Or OTC Pyrethrins In The Last 60 Days In Claims History Or Documented On PA Form/Fax
Spiriva HandiHaler CAPSULE 18 MCG Inhalation	Tiotropium Bromide Monohydrate	Prior Authorization Required	*Diagnosis of COPD (Emphysema, Chronic Bronchitis) *AND* *Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial Of) *Spiriva Respimat Cannot Be Used
Sprix Solution 15.75 MG/SPRAY Nasal	Ketorolac Tromethamine	Prior Authorization Required	*Diagnosis = Moderate To Severe Pain *Clinical Reason Supported By Chart Notes Why (After A Trial Of) Two Oral NSAIDs (Meloxicam, Naproxen, Ibuprofen, Diclofenac, Ketorolac, Celecoxib, etc.) Cannot Be Used *OR Patient Is Unable To Swallow, Has Dysphagia, Esophagitis, Mucositis, Or Uncontrollable Nausea/Vomiting (Must Be Documented In Chart Notes) *Total Duration Of Use Of Ketorlac Alone Or Sequentially With Other Formulations Of Ketorolac Must Not Exceed 5 Days (If Claims Of Ketorlac Will Exceed 5 Days, Will Require RPh Review*
Sprycel TABLET 100 MG ORAL	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Sprycel TABLET 140 MG ORAL	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Sprycel TABLET 20 MG ORAL	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Sprycel TABLET 50 MG ORAL	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Sprycel Tablet 70 MG Oral	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Sprycel TABLET 80 MG ORAL	Dasatinib	Prior Authorization Required	*Diagnosis = ALL (Acute Lymphoblastic Leukemia) Or CML (Chronic Myeloid Leukemia)
Steglatro TABLET 15 MG Oral	Ertugliflozin L-PyroglutamicAc	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Steglatro TABLET 5 MG Oral	Ertugliflozin L-PyroglutamicAc	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Sulfacetamide Sodium-Sulfur Liquid 9-4 % External		Prior Authorization Required	*90 Day Trial Of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium w/ Sulfur 10-5% Suspension, Sulfacetamide Sodium w/ Sulfur 10-5% Lotion, Or

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			Sulfacetamide Sodium w/ Sulfur Emulsion, Avar Cleanser, Rosanil, Or Prascion 10-5%
Sulfacetamide Sodium-Sulfur PAD 10-4 % EXTERNAL		Prior Authorization Required	*90 Day Trial Of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium w/ Sulfur 10-5% Suspension, Sulfacetamide Sodium w/ Sulfur 10-5% Lotion, Or Sulfacetamide Sodium w/ Sulfur Emulsion, Avar Cleanser, Rosanil, Or Prascion 10-5%
Sulfacetamide Sodium-Sulfur SUSPENSION 8-4 % EXTERNAL		Prior Authorization Required	*90 Day Trial Of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium w/ Sulfur 10-5% Suspension, Sulfacetamide Sodium w/ Sulfur 10-5% Lotion, Or Sulfacetamide Sodium w/ Sulfur Emulsion, Avar Cleanser, Rosanil, Or Prascion 10-5%
Sutent CAPSULE 12.5 MG ORAL	SUNItinib Malate	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors; Advanced Renal Cell Carcinoma; GI Stromal Tumor
Sutent CAPSULE 25 MG ORAL	SUNItinib Malate	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors; Advanced Renal Cell Carcinoma; GI Stromal Tumor
Sutent CAPSULE 37.5 MG ORAL	SUNItinib Malate	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors; Advanced Renal Cell Carcinoma; GI Stromal Tumor
Sutent CAPSULE 50 MG ORAL	SUNItinib Malate	Prior Authorization Required	*Diagnosis = Advanced Pancreatic Neuroendocrine Tumors; Advanced Renal Cell Carcinoma; GI Stromal Tumor
Sylatron KIT 200 MCG Subcutaneous	Peginterferon alfa-2b	Prior Authorization Required	*Diagnosis = Melanoma
Sylatron KIT 300 MCG Subcutaneous	Peginterferon alfa-2b	Prior Authorization Required	*Diagnosis = Melanoma
Sylatron KIT 600 MCG Subcutaneous	Peginterferon alfa-2b	Prior Authorization Required	*Diagnosis = Melanoma
SymlinPen 120 Solution Pen-Injector 2700 MCG/2.7ML Subcutaneous	Pramlintide Acetate	Prior Authorization Required	*60 Day Trial Of: Humalog, Novolog, Or Apidra
SymlinPen 60 Solution Pen-Injector 1500 MCG/1.5ML Subcutaneous	Pramlintide Acetate	Prior Authorization Required	*60 Day Trial Of: Humalog, Novolog, Or Apidra
Synagis Solution 100 MG/ML Intramuscular	Palivizumab	Prior Authorization Required	*Follow The Synagis Policy On CareSource.com

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Synagis Solution 50 MG/0.5ML Intramuscular	Palivizumab	Prior Authorization Required	*Follow The Synagis Policy On CareSource.com
Synarel SOLUTION 2 MG/ML NASAL	Nafarelin Acetate	Prior Authorization Required	*Diagnosis = Endometriosis
Tabloid TABLET 40 MG Oral	Thioguanine	Prior Authorization Required	*Diagnosis = For Remission Induction And Remission Consolidation Treatment Of Acute Nonlymphocytic Leukemias
Tafinlar CAPSULE 50 MG ORAL	Dabrafenib Mesylate	Prior Authorization Required	*Diagnosis = BRAFV600E-Mutated Melanoma That Is Metastatic Or Unresectable (Stage III Or Stage IV) And Is Being Used A Single Agent To Treat The Melanoma *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test (Chart Notes Are Required) OR *Diagnosis = BRAFV600E Or BRAF V600K-Mutated Melanomas That Is Metastatic Or Unresectable (Stage III Or Stage IV) And Is Given In Combination With Mekinist (Trametinib)) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test (Chart Notes Are Required)
Tafinlar CAPSULE 75 MG ORAL	Dabrafenib Mesylate	Prior Authorization Required	*Diagnosis = BRAFV600E-Mutated Melanoma That Is Metastatic Or Unresectable (Stage III Or Stage IV) And Is Being Used A Single Agent To Treat The Melanoma *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test (Chart Notes Are Required) OR *Diagnosis = BRAFV600E Or BRAF V600K-Mutated Melanomas That Is Metastatic Or Unresectable (Stage III Or Stage IV) And Is Given In Combination With Mekinist (Trametinib)) *Member Must Have Required BRAF Mutation Detected By An FDA Approved Test (Chart Notes Are Required)
Targretin Gel 1 % External	Bexarotene	Prior Authorization Required	*Diagnosis = Cutaneous T-Cell Lymphoma
Tasigna CAPSULE 150 MG ORAL	Nilotinib HCl	Prior Authorization Required	*Diagnosis = Chronic Myelogenous Leukemia
Tasigna CAPSULE 200 MG ORAL	Nilotinib HCl	Prior Authorization Required	*Diagnosis = Chronic Myelogenous Leukemia
Temozolomide Capsule 100 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme
Temozolomide Capsule 140 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme

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Temozolomide Capsule 180 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme
Temozolomide Capsule 20 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme
Temozolomide Capsule 250 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme
Temozolomide Capsule 5 MG Oral		Prior Authorization Required	*Diagnosis = Anaplastic Astrocytoma; Glioblastoma Multiforme
Testosterone Cypionate Solution 100 MG/ML Intramuscular		Prior Authorization Required	*Diagnosis = Hypogonadism; *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only); *OR* *Diagnosis = Gender Dysphoria (Must Be 18 Years And Above)
Testosterone Cypionate Solution 200 MG/ML Intramuscular		Prior Authorization Required	*Diagnosis = Hypogonadism; *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only); *OR* *Diagnosis = Gender Dysphoria (Must Be 18 Years And Above)
Testosterone Enanthate SOLUTION 200 MG/ML Intramuscular		Prior Authorization Required	*Diagnosis = Hypogonadism AND *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) *OR* *Diagnosis Of Gender Dysphoria (Must Be 18 Years And Above) *OR* *Diagnosis Of Breast Cancer (Female) *OR* *Diagnosis Of Delayed Puberty (Male)
Testosterone Gel 10 MG/ACT (2%) Transdermal		Prior Authorization Required	*Diagnosis of Hypogonadism; *Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only); *Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also) Cannot Be Used
Testosterone Gel 25 MG/2.5GM (1%) Transdermal		Prior Authorization Required	*Diagnosis of Hypogonadism; *Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only); *Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also) Cannot Be Used
Testosterone Gel 50 MG/5GM (1%) Transdermal		Prior Authorization Required	*Diagnosis of Hypogonadism; *Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only); *Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) *Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also) Cannot Be Used

Tetrabenazine Tablet 12.5 MG Oral		Prior Authorization Required	*Diagnosis = Chorea Associated With Huntington's Disease *OR* *Diagnosis = Moderate To Severe Tardive Dyskinesia Documented In Chart Notes *Age 18 Or Older *An Inadequate Treatment Response, Intolerance, Or Contraindication To Both Of The Following: A Benzodiazepine, A Second Generation Antipsychotic (Must Have Claims History) *A Documented Baseline Evaluation Of The Condition Using One Of The Following: Abnormal Involuntary Movement Scale (AIMS) > 10 OR Extrapyramidal Symptom Rating Scale (ESRI) > 20 *No Dual Therapy With Other Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors (Tetrabenazine, Austedo) *No Concomitant Use Of A MAOI (Monoamine Oxidase Inhibitor) Or Reserpine (Must Be >20 Days Post Discontinuing Therapy)
Tetrabenazine Tablet 25 MG Oral		Prior Authorization Required	*Diagnosis = Chorea Associated With Huntington's Disease *OR* *Diagnosis = Moderate To Severe Tardive Dyskinesia Documented In Chart Notes *Age 18 Or Older *An Inadequate Treatment Response, Intolerance, Or Contraindication To Both Of The Following: A Benzodiazepine, A Second Generation Antipsychotic (Must Have Claims History) *A Documented Baseline Evaluation Of The Condition Using One Of The Following: Abnormal Involuntary Movement Scale (AIMS) > 10 OR Extrapyramidal Symptom Rating Scale (ESRI) > 20 *No Dual Therapy With Other Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors (Tetrabenazine, Austedo) *No Concomitant Use Of A MAOI (Monoamine Oxidase Inhibitor) Or Reserpine (Must Be >20 Days Post Discontinuing Therapy)

traMADol HCl Tablet 50 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

Tramadol-Acetaminophen Tablet 37.5-325 MG Oral		Prior Authorization Required	**Initial Auths** *If Diagnosis Is One Of The Following, Will Approve X 6 Months: a) Active Cancer Treatment Or Cancer Related Pain, b) Palliative Care, c) End-Of-Life Or Hospice Care, d) Sickle Cell Anemia, e) Severe Burns, f) Traumatic Crushing Of Tissue, g) Amputation, h) Major Orthopedic Surgery OR *If Request Is For Post Discharge Or Post-Operative Within The Last 7 Days, Will Approve For Up To 14 Days OR *If Diagnosis Is Moderate To Severe Pain (List Diagnosis Code), AND *Member Has Not Been On Any Opioid In The Last 90 Days (Naïve Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Member Has Experienced An Inadequate Response, Intolerance Or Contraindication To At Least 2 Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Will Approve As Requested For Up To 90 Days, Up To Quantity Limit Or 30 MED (Whichever Is Lower) OR *Member On Opioids In The Last 90 Days (Chronic Utilizer): -Dose Is < 30 MED (See MED Chart On Preferred Immediate Release IR Opioids CAS Question Set) -Prescriber Attests To Discussing Benefits/Risks Of Opioids With Member -Prescriber Attests To Checking State PDMP -Duration Of Therapy: •Less Than 90 Days = Will Approve X 90 Days Up To Quantity Limit Or 30 MED (Whichever Is Lower) •If More Than 90 Days: -If Dose Is > 80 MED, Prescriber Is Pain Management, Pain Management Consulted, Or Pain Management Unavailable And Rationale For Higher Dose -Prescriber Attests To Patient Specific Treatment Plan -Prescriber Attests To Assessing For Addiction Risk Or Mental Health Concerns -If Patient Is Also Treated With A Benzodiazepine, Prescriber Attests That Benefit Of Using Both Together Outweighs Risk -Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower) **Reauth Criteria** If Previously Approved: *Member Meets All Initial Criteria AND *Prescriber Attests Or Documentation Submitted Supporting Benefit Of Continued Therapy Outweighs Risks To Patient Safety (e.g., Adherence, Progress Notes On Pain And Function Scores, Improvement In Function And/Or Quality Of Life, No Serious Adverse Outcomes) *Will Approve As Requested Up To 6 Months, Up To Quantity Limit Or 30 MED (Whichever Is Lower)

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Tranexamic Acid Tablet 650 MG Oral		Prior Authorization Required	*Diagnosis = Uterine Fibroids; *OR* *Diagnosis = Cyclic Heavy Menstrual Bleeding, DUB (Dysfunctional Uterine Bleeding), Menorrhagia, Excessive Bleeding, Or Dysmenorrhea *And Trials Per Age Groups Below: a) Age Over 50 Years Of Age = *No Trials Needed; b) Age 40-50 Years Of Age = *30 Day Trial Of: Medroxyprogesterone (Provera) Or Medroxyprogesterone Shot; c) *Age Under 40 Years Of Age *30 Day Trial Of: Formulary Oral Contraceptives, Nuvaring, Medroxyprogesterone (Provera) Or Medroxyprogesterone Shot
Trecator Tablet 250 MG Oral	Ethionamide	Prior Authorization Required	*Diagnosis = Tuberculosis
Trelstar Mixject Suspension Reconstituted 11.25 MG Intramuscular	Triptorelin Pamoate	Prior Authorization Required	*Diagnosis = Palliative Treatment Of Advanced Prostate Cancer *MD Specialty = Oncology
Trelstar Mixject SUSPENSION RECONSTITUTED 22.5 MG Intramuscular	Triptorelin Pamoate	Prior Authorization Required	*Diagnosis = Palliative Treatment Of Advanced Prostate Cancer *MD Specialty = Oncology
Trelstar Mixject SUSPENSION RECONSTITUTED 3.75 MG Intramuscular	Triptorelin Pamoate	Prior Authorization Required	*Diagnosis = Palliative Treatment Of Advanced Prostate Cancer *MD Specialty = Oncology
Treprostinil Solution 100 MG/20ML Injection		Prior Authorization Required	*Medical Benefit Only *Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Treprostinil Solution 20 MG/20ML Injection		Prior Authorization Required	*Medical Benefit Only *Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Treprostinil Solution 200 MG/20ML Injection		Prior Authorization Required	*Medical Benefit Only *Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Treprostinil Solution 50 MG/20ML Injection		Prior Authorization Required	*Medical Benefit Only *Follow The Pulmonary Arterial Hypertension Policy On CareSource.com
Tretinoin Cream 0.025 % External		Prior Authorization Required	*If Age Below 12 Or Over 26, The Following Diagnosis Is Required: *Diagnosis = Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea

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Tretinoin Cream 0.05 % External		Prior Authorization Required	*If Age Below 12 Or Over 26, The Following Diagnosis Is Required: *Diagnosis = Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea
Tretinoin Cream 0.1 % External		Prior Authorization Required	*If Age Below 12 Or Over 26, The Following Diagnosis Is Required: *Diagnosis = Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea
Tretinoin Gel 0.01 % External		Prior Authorization Required	*If Age Below 12 Or Over 26, The Following Diagnosis Is Required: *Diagnosis = Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea
Tretinoin Gel 0.025 % External		Prior Authorization Required	*If Age Below 12 Or Over 26, The Following Diagnosis Is Required: *Diagnosis = Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea
Triumeq Tablet 600-50-300 MG Oral	Abacavir-Dolutegravir-Lamivud	Prior Authorization Required	*Genetic Test To Confirm Negative For HLA-B*5701 Allele [Note: This Must Be Faxed In]
Trulance Tablet 3 MG Oral	Plecanatide	Prior Authorization Required	*Age 18 Or Older *Diagnosis = Chronic Idiopathic Constipation *OR* *Irritable Bowel Syndrome With Constipation (IBS-C) *7 Day Trial Of At Least ONE Of The Following Supported By Pharmacy Claims In The Last 30 Days: Methylcellulose (Citrucel), Psyllum (Metamucil), Polyethylene Glycol (Miralax), Bisacodyl (Dulcolax), Senna (Senokot), Docusate (Colace)
Trulicity Solution Pen-injector 0.75 MG/0.5ML Subcutaneous	Dulaglutide	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Trulicity Solution Pen-injector 1.5 MG/0.5ML Subcutaneous	Dulaglutide	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Tykerb TABLET 250 MG ORAL	Lapatinib Ditosylate	Prior Authorization Required	*Diagnosis = Breast Cancer

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Ulesfia LOTION 5 % EXTERNAL	Benzyl Alcohol	Prior Authorization Required	*Diagnosis = Head Lice (For Age 6 Months And Older) *One Time Trial Within The Last 30 Day Per Age Group Below: ***Age 6 Months Up To 2 Years Old: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Benzyl Alcohol Lotion (Ulesfia). ***Age 2 Years - 3 Years: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (RID Complete Kit), Or Benzyl Alcohol Lotion (Ulesfia). ***Age 4 Years To 5 Years Old: Lice Treatment Liquid 1%, Permethrin (RID Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (RID Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (RID Complete Kit), Or Benzyl Alcohol Lotion (Ulesfia). ***Age 6 Years And Older: Lice Treatment Liquid 1%, Permethrin (RID Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (RID Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (RID Complete Kit), Benzyl Alcohol Lotion (Ulesfia) Or Malathion (Ovide)
Veregen Ointment 15 % External	Sinecatechins	Prior Authorization Required	*Diagnosis = External Genital And Perianal Warts *A One Time Trial Of: Podofilox (Condylox) Solution
Victoza Solution Pen-Injector 18 MG/3ML Subcutaneous	Liraglutide	Prior Authorization Required	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER)
Vimpat TABLET 100 MG ORAL	Lacosamide	Prior Authorization Required	*Age= 4 Years And Older *Diagnosis = Seizure Or Epilepsy *30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Vimpat TABLET 150 MG ORAL	Lacosamide	Prior Authorization Required	*Age= 4 Years And Older *Diagnosis = Seizure Or Epilepsy *30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide

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Vimpat TABLET 200 MG ORAL	Lacosamide	Prior Authorization Required	*Age= 4 Years And Older *Diagnosis = Seizure Or Epilepsy *30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Vimpat TABLET 50 MG ORAL	Lacosamide	Prior Authorization Required	*Age= 4 Years And Older *Diagnosis = Seizure Or Epilepsy *30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Votrient TABLET 200 MG ORAL	Pazopanib HCl	Prior Authorization Required	*Diagnosis = Renal Cell Carcinoma OR Soft Tissue Sarcoma
WinRho SDF Solution 1500 UNIT/1.3ML Injection	Rho D Immune Globulin	Prior Authorization Required	*Medical Benefit Only*
WinRho SDF Solution 15000 UNIT/13ML Injection	Rho D Immune Globulin	Prior Authorization Required	*Medical Benefit Only*
WinRho SDF Solution 2500 UNIT/2.2ML Injection	Rho D Immune Globulin	Prior Authorization Required	*Medical Benefit Only*
WinRho SDF Solution 5000 UNIT/4.4ML Injection	Rho D Immune Globulin	Prior Authorization Required	*Medical Benefit Only*
Xalkori CAPSULE 200 MG ORAL	Crizotinib	Prior Authorization Required	*Diagnosis = Advanced Or Metastatic Non-Small Cell Lung Cancer (NSCLC) *MD Specialty = Oncology
Xalkori CAPSULE 250 MG ORAL	Crizotinib	Prior Authorization Required	*Diagnosis = Advanced Or Metastatic Non-Small Cell Lung Cancer (NSCLC) *MD Specialty = Oncology
Xeljanz Tablet 10 MG Oral	Tofacitinib Citrate	Prior Authorization Required	*Follow The Xeljanz Policy On CareSource.com
Xeljanz TABLET 5 MG ORAL	Tofacitinib Citrate	Prior Authorization Required	*Follow The Xeljanz Policy On CareSource.com
Xifaxan Tablet 200 MG Oral	Rifaximin	Prior Authorization Required	*Diagnosis = Travelers Diarrhea; *A One-Time Trial In The Last 30 Days Of: Ciprofloxacin Or Metronidazole Tablets

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Xiidra SOLUTION 5 % OPHTHALMIC	Lifitegrast	Prior Authorization Required	*Diagnosis = Dry Eye Disease *30 Day Trial Of At Least TWO Agents From Different Groups Of The Following Supported By Pharmacy Claims And/Or Specific Trial Date Listed On Request With Directions To Use QID Routinely For At Least 30 Days: Cellulose Based Artificial Tears: Refresh Tears, Refresh Plus, Refresh Optive, Refresh Celluvisc, Refresh Liquigel, Systane Lubricant Eye Gel, Genteal Mild, Genteal Moderate, GenTeal Gel (Severe), GenTeal Tears, Bion Tears, Visine Tears, TheraTears, RetainePovidone Based: Soothe Long Lasting Hydration, Soothe Hydration, Polyethylene Glycol Based Artificial Tears: Blink Tears, Systane, Systane Balance, Systane Ultra, Systane Gel, Systane Sport, Soothe Preservative Free Lubricant, Advanced Eye Relief Dry Eye Rejuvenation, Oasis Tears, Oasis Tears Plus PVA (Polyvinyl Alcohol)-Based Artificial Tears: Murine, Refresh Classic, Tears Again, HypoTearsOil-Based Tears: Soothe XP, Refresh PM, Refresh Lacrilube, Systane Nighttime, GeneTeal Ointment, Soothe Night Time Ointment, Retain PMOR
Xolair Solution Prefilled Syringe 150 MG/ML Subcutaneous	Omalizumab	Prior Authorization Required	*Follow The Xolair Policy On Caresource.com
Xolair Solution Prefilled Syringe 75 MG/0.5ML Subcutaneous	Omalizumab	Prior Authorization Required	*Follow The Xolair Policy On Caresource.com
Xtandi CAPSULE 40 MG ORAL	Enzalutamide	Prior Authorization Required	*Diagnosis = Metastatic Castration-Resistant Prostate Cancer
Zelboraf TABLET 240 MG Oral	Vemurafenib	Prior Authorization Required	*Diagnosis = 4800 BRAF V600E-Mutated Metastatic Melanoma *MD Specialty= Oncology
Zirgan Gel 0.15 % Ophthalmic	Ganciclovir	Prior Authorization Required	*Diagnosis = Acute Herpetic Keratitis (Dendritic Ulcers)
Zoladex IMPLANT 10.8 MG Subcutaneous	Goserelin Acetate	Prior Authorization Required	*Diagnosis = Advanced Breast Cancer, Advanced Prostatic Carcinoma, Or Stage B2 To C Prostatic Carcinoma OR *Diagnosis = Endometriosis (*One 6 Month Auth Only*) *90 Day Trial Of: Surgical Ablation, NSAIDs Or Contraceptives
Zoladex Implant 3.6 MG Subcutaneous	Goserelin Acetate	Prior Authorization Required	*Diagnosis = Advanced Breast Cancer, Advanced Prostatic Carcinoma, Or Stage B2 To C Prostatic Carcinoma OR *Diagnosis = Endometriosis (*One 6 Month Auth Only*) *90 Day Trial Of: Surgical Ablation, NSAIDs Or Contraceptives

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Zolinza CAPSULE 100 MG ORAL	Vorinostat	Prior Authorization Required	*Diagnosis = Cutaneous T-Cell Lymphoma (CTCL)
Zubsolv TABLET SUBLINGUAL 0.7-0.18 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Zubsolv TABLET SUBLINGUAL 1.4-0.36 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Zubsolv TABLET SUBLINGUAL 11.4-2.9 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine

Zubsolv TABLET SUBLINGUAL 2.9-0.71 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Zubsolv TABLET SUBLINGUAL 5.7-1.4 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Zubsolv TABLET SUBLINGUAL 8.6-2.1 MG SUBLINGUAL	Buprenorphine HCl-Naloxone HCl	Prior Authorization Required	*Product Is Preferred With No PA But Must Follow Safety Edits Listed On Zubsolv (Buprenorphine And Naloxone) Policy On CareSource.com. PA IS NEEDED FOR: a) Individuals Who Are 15 Years Of Age Or Younger; Or b) Individuals Who Are Male And Receiving Short Acting Buprenorphine Without Naloxone; Or c) Individuals Who Are Female And Receiving Short Acting Buprenorphine Without Naloxone And 15 Years Of Age Or Younger OR 45 Years Of Age Or Older; Or d) Dosages That Are Greater Than 24 mg/Day; Or e) Dosages Over 16 mg/Day Beginning 90 Days After The Initial Fill; f) Long-Acting Or Injectable Buprenorphine
Zykadia CAPSULE 150 MG ORAL	Ceritinib	Prior Authorization Required	*Diagnosis = Advanced Or Metastatic Non-Small Cell Lung Cancer (NSCLC) *MD Specialty = Oncology