Formulary Exception Criteria for Non-Covered Products

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Product Identifiers (PID)

Refer to the Product-Specific Exception Criteria Table for unique PID

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

This policy may be updated on a monthly basis following Pharmacy & Therapeutics (P&T) review of new and/or updated formulary exception criteria.

National Formulary Medical Necessity

The Cigna National Formulary prescription drug list does not cover certain drugs or biologics unless those products are approved based upon a medical necessity review.

Cigna covers these drugs or biologics as medically necessary when the following criteria are met:

- [see Product-Specific Exception Criteria]

Approval duration is 12 months unless otherwise noted.

Documentation: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

Product-Specific Exception Criteria

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Absorica LD PID: 101353 **Effective 7/1/2022**	isotretinoin capsules low dose	**1.** Approve if the individual has tried three of the following: Absorica (not LD), Accutane, Amnesteem, Claravis, Myorisan, or Zenatane, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve.
Aciphex Sprinkle and authorized generic PID: 38897	rabeprazole sodium delayed-release capsules	**2.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole orally dissolving tablets (Prevacid/Solutabs, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **3.** Individuals < 18 years of age OR individuals who have difficulty swallowing tablets/capsules: Approve if the individual has tried two proton pump inhibitors (PPIs). **Note:** The requested agent would NOT count as a trial of an alternative. **Note:** If an approval is entered, it will be entered for the authorized generic.
Acuvail PID: 13625	ketorolac tromethamine 0.45% preservative-free solution	**1.** Approve if the individual has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), bromfenac 0.09% ophthalmic solution (generics), Prolensa, BromSite, Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **2.** Individuals with a sulfite allergy: approve if the individual has tried two of the following, if two are formulary (or one if only one is formulary): BromSite, diclofenac ophthalmic solution (generics), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **3.** Individuals with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]): approve if the individual has tried diclofenac ophthalmic solution (generics), if formulary. If diclofenac ophthalmic solution is non-formulary, approve.
Adlyxin PID: 57661	lixisenatide injection	**1.** Approve if the individual has tried three formulary alternatives from the following list (or two if two are formulary or one if only one is formulary): Trulicity, an exenatide product (Byetta, Bydureon BCise), Ozempic, or Victoza **[documentation required].** If none are formulary, approve. **NOTE:** Bydureon BCise and Byetta would count as one alternative. **2.** Individual with estimated creatinine clearance (CrCl) < 45 mL/min: Approve if the individual has tried two formulary alternatives from the following list (or one if one is formulary): Trulicity, Victoza, or Ozempic **[documentation required].** If none are formulary, approve. **3.** Individual with a personal or family history of medullary thyroid carcinoma or an individual with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2):

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		approve if the individual has tried Byetta **[documentation required],** if formulary. If Byetta is non-formulary, approve. Note: If the individual has tried Bydureon or Bydureon BCise, this would satisfy the requirement.
Admelog PID: 61633	insulin lispro vial, SoloStar (prefilled pen)	Approve if the individual meets the following (1 or 2): **1.** Individual meets the following (A, B, and C): A. Individual has tried Apidra, if formulary; AND B. Individual has one of the following, if formulary: Insulin Lispro (authorized generic of Humalog) or Humalog; AND C. Individual has tried one of the following, if formulary: NovoLog, or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR **2.** Individual is using an insulin pump that is not compatible with the formulary alternative(s), approve. Note: If no products in A, B, or C are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).
Adzenys XR suspension and authorized generic [Authorized generic only] PID: 61571	amphetamine extended-release oral suspension	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five central nervous system (CNS) stimulants. **Note**: Examples of central nervous system stimulants include: amphetamine sulfate, mixed amphetamine salts (Adderall, generics), amphetamine aspartate extended-release capsules (Adderall XR, generics); methylphenidate extended-release tablets (Concerta, generics); dextroamphetamine sulfate sustained-release capsules (Dexedrine Spansules, generics); dexmethylphenidate extended-release capsules (Focalin, Focalin XR, generics); methylphenidate extended-release tablets or capsules, or sustained-release tablets (Metadate CD, Metadate ER, Methylin ER, Ritalin LA, Ritalin-SR).
Afrezza PID: 49801	insulin human [rDNA origin] inhalation powder	Approve if the individual meets the following (A, B, C and D): A. Individual has tried Apidra, if formulary; AND B. Individual has tried Fiasp, if formulary; AND C. Individual has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic); AND D. Individual has tried one of the following, if formulary: Insulin Lispro (authorized generic), Humalog, or Admelog. Note: If no products in A, B, C, or D are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).

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AirDuo RespiClick PID: 59643	fluticasone propionate/salmeterol inhalation powder	**1.** Approve if the individual has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Advair HFA, fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), Breo Ellipta, Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (authorized generic of AirDuo RespiClick), AirDuo Digihaler, or Symbicort. If none are formulary, approve. **2.** Individuals who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), AirDuo Digihaler, or Breo Ellipta. If none are formulary, approve. **3.** Individuals < 18 years of age: approve if the individual has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): Symbicort, Advair HFA, fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), AirDuo Digihaler, or Dulera. If none are formulary, approve. **4.** Individuals < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried one of fluticasone propionate/salmeterol inhalation, Wixela (Advair Diskus, generics) or fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), or AirDuo Digihaler, if one is formulary. If none are formulary, approve. **Note**: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick) and AirDuo Digihaler would count as one alternative.
Akynzeo PID: 48992	netupitant/ palonosetron capsules	**1.** Approve if the individual has tried two formulary 5-HT3 receptor antagonists from the following list (if two are formulary or one if one is formulary [if none are formulary, approve]): ondansetron (Zofran, generics), granisetron (generics), or Sancuso AND one of aprepitant capsules (Emend, generics) or Varubi tablets, if one is formulary. If neither are formulary, approve. **2.** Approve if the individual has already started Akynzeo to complete all cycles in the current course of chemotherapy.
albuterol HFA inhaler PID: 65949	albuterol sulfate inhalation aerosol (authorized generic to Ventolin HFA)	**1.** Individual is directed to use Ventolin HFA (brand). If Ventolin HFA (brand) is non-formulary, approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), ProAir Respiclick, ProAir Digihaler, Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Individuals < 12 years of age or individuals who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): Individual is directed to use Ventolin HFA (brand). If Ventolin HFA (brand) is non-formulary, approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve.

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Alcortin A PID: 51571, 51572	hydrocortisone 2%/ iodoquinol 1%/ aloe 1% gel	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five single-entity corticosteroid topical agents AND one prescription topical anti-infective agent. **Note**: Examples of topical corticosteroids include: hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]. **Note**: Examples of prescription topical anti-infectives include: mupirocin 2% cream [Bactroban, generics], mupirocin 2% ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).
Alkindi Sprinkle PID: 90562, 90923	hydrocortisone oral granules	**1.** Approve if the individual has tried and cannot take hydrocortisone tablets. **2.** Approve if the individual cannot swallow or has difficulty swallowing hydrocortisone tablets. **3.** Approve if the individual's dose cannot be obtained using whole hydrocortisone tablets.
Allzital tablet PID: 58422	butalbital 25 mg, acetaminophen 325 mg tablet	1. Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Alocril PID: 62932	nedocromil sodium 2% ophthalmic solution	**1.** Approve if the individual has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.
alogliptin and metformin tablets PID: 24615	alogliptin and metformin tablets (authorized generic of Kazano)	**1.** Approve if the individual has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kombiglyze XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics). **Note**: Janumet and Janumet XR would count as one alternative. Jentadueto and Jentadueto XR would count as one alternative.
alogliptin and pioglitazone tablets PID: 24635	alogliptin and pioglitazone tablets (authorized generic of Oseni)	**1.** Approve if the individual has tried pioglitazone (Actos, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the individual has tried pioglitazone (Actos, generics). **Note:** A trial of Oseni or the alogliptin and pioglitazone combination tablets (authorized generics) would not count toward this requirement.

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Alomide PID: 62933	lodoxamide tromethamine 0.1% ophthalmic solution	**1.** Approve if the individual has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve. **2.** For a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and vernal keratitis, approve if the individual has tried cromolyn sodium 4% solution (generics). If cromolyn sodium 4% solution (generic) is non-formulary, approve.
Alrex PID: 47496	loteprednol etabonate 0.2% ophthalmic suspension	**1.** Approve if the individual has tried three products from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): bepotastine ophthalmic drops (Bepreve, generics), cromolyn ophthalmic drops (generics), epinastine 0.05% solution (generics), Lastacaft, azelastine 0.05% solution (generics), olopatadine ophthalmic solution (generics), Zerviate. If none are formulary, approve. **2.** Individuals who require concurrent use of Alrex with an H1 antagonist or an H1 antagonist/mast cell stabilizer (e.g. azelastine [generics], bepotastine, epinastine solution [generics], Lastacaft, olopatadine ophthalmic solution [generics], Zerviate): approve.
Altoprev PID: 51357	lovastatin extended-release tablets	**1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin {Lipitor, generics}, rosuvastatin {Crestor, generics}, fluvastatin, {Lescol/XL, generics}, pitavastatin {Livalo, Nikita, Zypitamag}, pravastatin {Pravachol}, Livalo, or simvastatin {Zocor, generics}. If none are formulary, approve.
Amitiza and authorized generic PID: 13223	lubiprostone capsules	**1.** Approve if the individual has tried three products from the following list: Linzess, Trulance, or Motegrity, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** Individuals with irritable bowel syndrome with constipation: approve if the individual has tried both products from the following list: Linzess and Trulance, if both are formulary (or one if one is formulary). If neither are formulary, approve. **3.** Chronic opioid- induced constipation: approve if the individual has tried three of Movantik, Symproic, or Relistor tablets, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve if individual has tried two laxative agents (e.g., bisacodyl containing products, senna containing products, milk of magnesia, lactulose).
Amrix and generic PID: 49418, 49779	cyclobenzaprine extended-release 15 mg and 30 mg capsule	**1.** Approve if the individual has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.
Android PID: 49787	methyltestosterone 10 mg capsules	**1.** Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): methyltestosterone capsules (Testred, generics) or Methitest. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Annovera PID: 71215	segesterone acetate and ethinyl estradiol vaginal system	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried three other contraceptive agents (e.g., oral contraceptives tablets, Twirla [contraceptive patch], Xulane [contraceptive patch], Eluryng [contraceptive vaginal ring], etonogestrel-ethinyl estradiol ring [contracetive vaginal ring], NuvaRing [contraceptive vaginal ring]); OR Note: A trial of the three different oral contraceptive agents would meet the requirement. **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Antara PID: 13347 **Effective 7/1/2022**	fenofibrate capsules	**1.** Approve if the individual has tried three other formulary fenofibrate products (e.g., TriCor or generic, Antara, Triglide, Lipofen, Fenoglide or generic, Trilipix or generic, generic fenofibrate capsule/ tablets, Fibricor or generic, generic fenofibric acid tablets) or two if only two are formulary, or one if only one is formulary. If none are formulary approve the requested agent.
Antivert 50 mg tablet PID: 97198, 97199	meclizine 50 mg tablet	**2.** Individual meets both of the following (i and ii): i. Individual has tried generic 25 mg tablets; AND ii. Individual cannot take generic 25 mg tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Apadaz and authorized generic PID: 65918	benzhydrocodone and acetaminophen tablets	**1.** Approve if the individual has tried two other hydrocodone/acetaminophen containing products (e.g., Vicodin, Vicodin ES, Norco, Lortab, Lorcet, multiple generics). Approval duration: 1 month
Apidra PID: 13360	insulin glulisine vial/Solostar (prefilled pen)	Approve if the individual meets the following (1 or 2): **1.** Individual meets the following (A and B): A. Individual has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Admelog; AND Note: A previous trial of Lyumjev would satisfy this requirement. B. Individual has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR **2.** Individual is using an insulin pump that is not compatible with the formulary alternative(s), approve. Note: If no products in A or B are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).
Apokyn PID: 82922	apomorphine injection	**1.** Parkinson's Disease: Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Kynmobi, if formulary. If Kynmobi is non-formulary, approve. **2.** Approve if the individual has already been started on Apokyn.

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Aptiom PID: 41712	eslicarbazepine acetate tablets	**1.** Approve if the individual has tried three other antiepileptic agents (e.g., Vimpat tablets or oral solution, topiramate [Topamax, generics], lamotrigine [Lamictal, generics], gabapentin [Neurontin, generics], zonisamide [Zonegran, generics], Lyrica, oxcarbazepine [Trileptal, generics], levetiracetam [Keppra, Keppra XR, generics], divalproex sodium [Depakote, Depakote ER, generics], carbamazepine [Tegretol, Tegretol XR, generics], Spritam, Fycompa, Briviact, Qudexy XR, Trokendi XR, Oxtellar XR). **2.** Approve if the individual has been started on Aptiom or has taken Aptiom in the past.
ArmonAir Digihaler PID: 88957	fluticasone propionate powder, metered	**1.** Approve if the individual has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus, Flovent HFA), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the individual is < 12 years of age, approve if the individual has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus, Flovent HFA), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. i. If the individual is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the individual has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. b. If the individual is < 6 years of age, approve if the individual has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus, Flovent HFA), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. i. If the individual is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the individual has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus), or Qvar RediHaler. If none are formulary, approve. c. If the individual is ≤ 4 years of age, approve if the individual has tried three formulary alternatives from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Flovent Diskus, Flovent HFA), or Qvar RediHaler. If none are formulary, approve. i. If the individual is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the individual has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only

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		one is formulary): Asmanex Twisthaler, Flovent Diskus, or Qvar RediHaler. If none are formulary, approve. **2.** If the individual is unable to coordinate breath and actuation with a conventional metered-dosen inhaler, approve if the individual has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, Flovent Diskus), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve.
Astagraf XL PID: 49784	tacrolimus extended-release capsules	**1.** Approve if the individual has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** If the individual has already started on therapy with Astagraf XL, approve.
Aveed PID: 43992	testosterone undecanoate for intramuscular use	**1.** Approve if the individual has tried one of the following injectable testosterone products, if one is formulary: testosterone enanthate injection [generics], testosterone cypionate injection [Depo-Testosterone, generics], or Xyosted. If none are formulary, approve.
Balcoltra PID: 91404	ethinyl estradiol 0.02 mg; levonorgestrel 0.1 mg; ferrous bisglycinate tablet	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried four other oral contraceptive agents; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Beconase AQ PID: 13779	beclomethasone nasal spray	**1.** Approve if the individual has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone nasal spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, Qnasl, or Zetonna. **Note:** Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Besivance PID: 13544	besifloxacin ophthalmic suspension 0.6%	**1.** Approve if the individual has tried two products from the following list, (if two are formulary, or one if one is formulary): gatifloxacin 0.5% ophthalmic solution (Zymaxid, generics), Moxeza, moxifloxacin 0.5% ophthalmic solution (Vigamox, generics), levofloxacin 0.5% ophthalmic solution, ofloxacin 0.3% ophthalmic solution (Ocuflox, generics), or ciprofloxacin 0.3% ophthalmic solution (Ciloxan, generics). If none are formulary, approve. **2.** Approve if there is laboratory data that the individual has an eye infection due to pathogens resistant to ciprofloxacin and one other ophthalmic quinolone. **3.** For the treatment of currently active eye infections: approve in individuals already receiving Besivance therapy to complete the course of therapy.
Besremi PID: 100654	ropeginterferon alfa-2b-njft subcutaneous injection	<u>Polycythemia vera in an individual ≥ 18 years of age.</u> **1.** Approve if the individual meets the following (A and B): A. Individual meets one of the following (i or ii): i. Individual has tried hydroxyurea, if formulary. If hydroxyurea is non-formulary, the individual would still have to try Pegasys, if formulary; OR ii. According to the prescriber, the individual is NOT a candidate for hydroxyurea therapy; AND Note: Examples of individuals who may be considered as NOT candidates for hydroxyurea

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		include pregnant individuals or younger adult individuals. B. Individual has tried Pegasys, if formulary. If Pegasys is non-formulary, the individual would still have to meet Criteria 1A above. Note: If neither hydroxyurea nor Pegasys are formulary, approve. **2.** Individual with low-risk polycythemia vera: Approve. **3.** Approve if the individual has already started on therapy with Besremi.
Betimol PID: 55783	timolol hemihydrates 0.25% and 0.5% ophthalmic solution	**1.** Approve if the individual has tried four of the following, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): levobunolol ophthalmic solution (Betagan, generics), timolol once-daily (Istalol, generics), betaxolol ophthalmic solution (generics), Betoptic S, carteolol opthalmic solution (generics),, timolol (Timoptic, generics), Timoptic in Ocudose, and timolol gel-forming solution (Timoptic XE, generics). If none are formulary, approve.
Bijuva PID: 64638	estradiol 1 mg and progesterone 100 mg capsules	**1.** Approve if the individual meets the following (A, B and C): A. Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND B. Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND C. Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Premphase or Prempro, if formulary. Note: If none are formulary in A, B and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Bonjesta PID: 62012 **Effective 7/1/2022**	doxylamine succinate and pyridoxine hydrochloride extended-release tablets	**1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with doxylamine-pyridoxine (Diclegis, generics), if formulary. If doxylamine-pyridoxine (Diclegis, generics) are non-formulary, approve if the individual has tried doxylamine AND pyridoxine (Vitamin B6).
Brexafemme PID: 95815	ibrexafungerp tablets	**2.** Approve if the individual has tried oral fluconazole.
BromSite PID: 56713	bromfenac 0.075% ophthalmic solution	**1.** Approve if the individual has tried two products from the following list (if two are formulary, or one of the following if one is formulary): Nevanac, Ilevro, diclofenac ophthalmic solution (generics), Acuvail, ketorolac ophthalmic solution (Acular, Acular LS, generics), bromfenac 0.09% ophthalmic solution (generics), or Prolensa. If none of the agents are formulary, then approve. **2.** Individuals with a sulfite allergy: approve if the individual has tried two of the following, if two are formulary (or one if only one is formulary): diclofenac ophthalmic solution (generics), Nevanac, Ilevro, Acuvail, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
budesonide-formoterol (authorized generic of Symbicort) PID: 80124	budesonide-formoterol (inhalation aerosol)	**1.** The individual is directed to use Symbicort (brand), if formulary. If Symbicort (brand) is non-formulary, approve if the individual has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): Advair HFA, fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), AirDuo Digihaler, Breo Ellipta, or Dulera. If none are formulary, approve. **2.** Individuals < 18 years of age: approve if the individual has tried two of the following (if two are formulary or one if only one is formulary): Advair HFA, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), AirDuo Digihaler, Dulera, or fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics). If none are formulary, approve. **3.** Individuals < 12 years of age: approve if the individual has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics) or Dulera. If none are non-formulary, approve. **4.** Individuals < 12 years of age with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the individual has tried Dulera, if formulary. If Dulera is non-formulary, approve. **5.** Individuals with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the individual has tried both Advair HFA and Dulera (if both are formulary or one if only one is formulary). If neither are formulary, approve. **6.** Individuals with COPD: Approve if the individual has tried both fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics) and Breo Ellipta (if both are formulary or one if only one is formulary). If none are formulary, approve. **7.** Individuals with COPD AND a low inspiratory flow rate who are unable to use a dry-powder inhaler (DPI): approve. **Note**: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler, AirDuo RespiClick, and AirDuo Digihaler count as one alternative.
Bupap tablet PID: 58421, 58422	butalbital 50 mg, acetaminophen 300 mg tablet	**1.** Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Bynfezia Pen PID: 99528	octreotide acetate injection for subcutaneous use	**1.** Approve if the individual has tried octreotide acetate injection (Sandostatin, generics) [NOT long-acting], if formulary. If octreotide acetate injection (Sandostatin, generics) [NOT long-acting] is non-formulary, approve.
Carac and authorized generic 0.5% PID: 13761	fluorouracil 0.5% cream	**1.** Approve if the individual has tried one of the following products, if formulary: Tolak, Fluoroplex, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Carospir PID: 60866, 60863 **Effective 7/1/2022**	spironolactone oral suspension	**1.** Approve if the individual has tried and cannot take spironolactone tablets (Aldactone, generics), if formulary. If spironolactone tablets (Aldactone, generics) are non-formulary, approve. **2.** Approve if the individual cannot swallow spironolactone tablets.
Cetraxal PID: 13296	ciprofloxacin 0.2% otic solution	**1.** Approve if the individual has tried one of the following, if one is formulary: ofloxacin otic solution (generics) or ciprofloxacin 0.2% otic solution (generic). If none are formulary, approve.
Ciloxan ointment PID: 87739	ciprofloxacin ophthalmic ointment 0.3%	**2.** Approve if the individual has tried four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): ciprofloxacin 0.3% ophthalmic solution (Ciloxan, generics), gatifloxacin 0.5% ophthalmic solution (Zymaxid, generics), moxifloxacin 0.5% ophthalmic solution (Vigamox, generics), levofloxacin 0.5% ophthalmic solution, or ofloxacin 0.3% ophthalmic solution (Ocuflox, generics). If none are formulary, approve. **3.** If the individual is allergic to benzalkonium chloride, approve if the individual has tried moxifloxacin (Vigamox, generics), if formulary. If moxifloxacin (Vigamox, generics) are non-formulary, approve. **4.** For the treatment of currently active eye infections: approve in individuals already receiving Ciloxan ointment to complete the course of therapy.
Cimzia PID: 13288	certolizumab powder for injection	**1.** See Inflammatory Conditions - Cimzia PSM Policy criteria
Cipro HC Otic Suspension PID: 13446	ciprofloxacin/ hydrocortisone otic suspension, 0.2%/1%	**1.** Approve if the individual has tried both products from the following list: ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel otic solution, if formulary. If none are formulary, approve. **2.** Individual has a benzalkonium chloride sensitivity: approve if the individual has tried one of ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel, if formulary. If neither are formulary, approve.
ciprofloxacin/ fluocinolone otic solution (authorized generic to Otovel) PID: 77877	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Direct the individual to Otovel (brand), if formulary. **2.** If Otovel (brand) is non-formulary, approve if the individual has tried both ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and Cipro HC otic suspension (or one if one is formulary). If neither are formulary, approve. **3.** If Otovel (brand) is non-formulary, individuals treating acute otitis media through tympanostomy tubes (AOMT), individuals with a perforated ear drum (tympanic membrane), or individuals < 1 year of age: approve if the individual has tried ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		4. If Otovel (brand) is non-formulary, individual has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve.
citalopram 30 mg capsules PID: 103300	citalopram capsules	**1.** Direct to citalopram tablets.
Clenia Plus PID: 96492	sodium sulfacetamide 9%-sulfur 4.25% suspension	**1.** Direct the individual to a topical product containing sodium sulfacetamide/sulfur (e.g., Sulfacetamide Sod 10%, Sulfur 5%, Topical suspension).
Clenpiq PID: 91753	sodium picosulfate; magnesium oxide; anhydrous citric acid solution	**1.** Approve if the individual meets one of the following criteria (a, b, c, d, or e): a. Individual has tried PEG3350 powder packet (Moviprep, generics). If PEG3350 powder packet (Moviprep, generics) are non-formulary, approve; OR b. If PEG3350 powder packet (generic of Moviprep) is unavailable; OR c. The individual is less than 18 years of age; OR d. Individuals with phenylketonuria; OR e. Individuals with glucose-6-phosphate dehydrogenase deficiency. Approval duration: 1 month
Climara Pro PID: 13095	estradiol/ levonorgestrel patch	**1.** Approve if the individual has tried CombiPatch, if formulary. If CombiPatch is non-formulary, approve if the individual has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).
Clindagel 1% gel and authorized generic PID: 81526	clindamycin 1% gel	**1.** Approve if the individual has tried topical clindamycin phosphate gel AND topical erythromycin gel.
Cloderm cream (and authorized generic) [Authorized generic only] PID: 66742	clocortolone pivalate 0.1% cream	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **Note**: Examples of topical steroid products include: betamethasone, fluocinolone acetonide, hydrocortisone valerate, mometasone, triamcinolone acetonide. **Note**: The five products must be chemically unique (i.e., a trial of betamethasone 0.1% and 0.05% would NOT fulfill the requirement).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
colchicine capsules PID: 48856	colchicine capsules	**1.** Approve if the individual has tried one product from the following list: colchicine tablets (Colcrys, generics), Mitigare capsules, or Gloperba oral solution, if one is formulary. If none are formulary, approve.
Complera PID: 53818	emtricitabline/rilpivirine/tenofovir disoproxil fumarate (TDF) tablets	**1.** Approve if the individual has tried Odefsey, if formulary. If Odefsey is non-formulary, approve if the individual has tried one of the following products: Biktarvy, Genvoya, Stribild, Triumeq, Symtuza, Atripla, Symfi (generics) or Symfi Lo (generics), if formulary. If none are formulary, approve. **2.** Approve if the individual is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir disoproxil fumarate and is requesting Complera for a single-table regimen. **3.** Individuals already started on therapy with Complera: approve.
Conjupri PID: 87746	levamlodipine tablets	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four formulary products from the following list: amlodipine, felodipine, nifedipine LA, nisoldipine (if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary). **2.** If the individual is < 18 years of age, approve if the individual has tried amlodipine, if formulary. If amlodipine is non-formulary, approve.
Corlanor PID: 71373	ivabradine tablets and solution	**1.** Approve if the individual has tried, or is currently taking a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) OR the individual has a contraindication to beta-blockers. **2.** Heart failure due to dilated cardiomyopathy, approve if the individual is < 18 years of age. **3.** Inappropriate sinus tachycardia: approve. **4.** Approve if the individual has already been started on Corlanor.
Cortifoam PID: 49333	hydrocortisone acetate aerosol foam	**1.** Approve if the individual has tried Uceris foam, if formulary. If Uceris foam is non-formulary, approve if the individual has tried one corticosteroid enema from the following list (if one is formulary): Cortenema or hydrocortisone enema.. If none are formulary, approve. **2.** Individuals who are unable to retain a corticosteroid enema: approve if the individual has tried Uceris, if formulary. If Uceris non-formulary, approve.
Cortrophin Gel (Purified) PID: 102168	repository corticotropin subcutaneous or intramuscular injection	**1.** No exceptions are recommended. There is a lack of updated clinical efficacy data and potential safety concerns with long-term use. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There is a lack of updated clinical efficacy data and insufficient information to determine clinically meaningful benefits.)
Cosentyx PID: 50326	secukinumab for SC injection	**1.** See *Inflammatory Conditions - Cosentyx PSM Policy criteria.*
Crinone 4% Gel PID: 42340	progesterone gel 4%	**1.** Approve if the individual has tried one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone tablets [Nor-Q.D., Jolivette, Aygestin, generics], or progesterone capsules (Prometrium, generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Crinone 8% Gel PID: 13228	progesterone gel 8%	**1.** For use as progesterone supplementation/replacement to achieve or maintain pregnancy: approve if the individual has tried Endometrin, if formulary. If Endometrin is non-formulary, approve. **2.** Individuals started on a course of therapy with Crinone 8% gel for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of therapy. **3.** Approve if the individual has tried one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone tablets [Nor-Q.D., Jolivette, Aygestin, generics], or progesterone capsules (Prometrium, generics). If none are formulary, approve.
Cystadrops PID: 87605	cysteamine ophthalmic solution	**1.** Cystinosis with Corneal Cysteine Crystal Deposits: Approve, if the individual has tried Cystaran, if formulary. If Cystaran is non-formulary, approve.
Daliresp PID: 13760	roflumilast tablets	Individual meets ONE of the following (A or B): A. Approve if the individual has tried an inhaled long-acting beta2-agonist, an inhaled long-acting muscarinic antagonist, and an inhaled corticosteroid concomitantly; OR B. If the individual has a blood eosinophil level < 100 cells/microliter, approve if the individual has tried an inhaled long-acting muscarinic antagonist and long-acting beta2-agonist concomitantly. <u>Note:</u> Use of a combination inhaler containing multiple agents from the medication classes listed would fulfil the requirement. Examples of an inhaled long-acting beta2-agonists include Arcapta Neohaler, Serevent Diskus, Striverdi Respimat, Brovana, and Perforomist. Examples of a long-acting muscarinic antagonists include Incruse Ellipta, Seebri Neohaler, Spiriva HandiHaler, Spiriva Respimat, Tudorza Pressair, Lonhala Magnair, and Yupelri. Examples of inhaled corticosteroids include Alvesco, ArmonAir Digihaler, Arnuity Ellipta, Asmanex Twisthaler/HFA, Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar RediHaler, and budesonide suspension for inhalation (Pulmicort Respules, generics). Examples of inhaled corticosteroid/long-acting beta2-agonist combination inhalers include Advair Diskus (generic Wixela Inhub; authorized generics), Breo Ellipta, and Symbicort. Examples of long-acting muscarinic antagonist/long-acting beta2-agonist combination inhalers include Anoro Ellipta, Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat, and Utibron Neohaler. Examples of corticosteroid/long-acting beta2-agonist/long-acting muscarinic antagonist combination inhalers are Breztri Aerosphere and Trelegy Ellipta.
Dartisla ODT PID: 101360	glycopyrrolate orally disintegrating tablets	**1.** Direct individual to glycopyrrolate tablets.
Delstrigo PID: 63932	doravirine/lamivudine/tenofovir disoproxil fumarate tablets	**1.** Approve if the individual has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, Complera, Triumeq, Symtuza, Symfi (generics) or Symfi Lo (generics), if formulary. If none are formulary, approve. **2.** Individual < 18 years of age AND weighing ≥ 35 kg (77 pounds), approve if the individual has tried one of Biktarvy, Genvoya, Odefsey, Stribild, Complera, or Symfi Lo, if formulary. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		3. Approve if the individual is currently taking single-entity or combination products containing doravirine, lamivudine, and tenofovir disoproxil fumarate and is requesting Delstrigo for a single tablet regimen. **4.** Individuals already started on therapy with Delstrigo, approve.
Dexilant and authorized generic PID: 13419	dexlansoprazole delayed-release capsules	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). Note: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). Note: The requested agent would NOT count as a trial of an alternative. **2.** Individuals < 18 years of age OR individuals who have difficulty swallowing tablets/capsules: Approve if the individual has tried four proton pump inhibitors (PPIs) from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): 1) rabeprazole sprinkle; 2) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 3) pantoprazole suspension (granules) [Protonix suspension, generic]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.
DexPak 6 day/10 day/13 day and generics PID: 59120	dexamethasone 1.5 mg tablets (6 day, 10 day, and 13 day dose pack)	1. The individual is directed to use the dexamethasone 1.5 mg tablets (not packed as dose packs). If dexamethasone 1.5 mg tablets (not packaged as dose packs) are non-formulary, approve. Approval duration: 14 days
Dhivy PID: 100749	carbidopa and levodopa immediate-release tablets	**1.** Direct the individual to carbidopa-levodopa tablets (Sinemet, generics).
Diabetic Supplies PID: 31692	Blood glucose meters/test strips/control solutions/continuous glucose monitoring products	**1.** Approve if the individual has tried one formulary meter/test strip/control solution (e.g. Freestyle, One Touch, Verio, Verio Flex, Precision, Accu-Check, Breeze, Contour, Truetest, Truetrack). If none are formulary, approve. **Note**: This is not an all-inclusive list of blood glucose meters/test strips/control solutions. **Note**: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **2.** If requesting a continuous glucose monitoring (CGM) monitor/receiver or supplies (sensor, transmitter), approve if the individual has tried one formulary CGM product (e.g., Freestyle Libre, Dexcom, Eversense). If no CGMs are formulary, approve if the individual has tried one traditional formulary meter/test strip/control solution. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: This is not an all-inclusive list of continuous glucose monitoring products. **Note**: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **3.** Individuals who are blind or significantly visually impaired who are requesting a meter with audio capabilities: approve if the individual has tried one other formulary meter with audio capabilities (e.g., Advocate [Redi-Code], Arkray [Glucocard Expression, Glucocard Shine Express], Foracare [Fora D40D, Fora D40G, For a Premium V10 BLE, Fora Test N' Go, For a Tn'G Voice, Fora V30], Oak Tree Health [EasyMax V, Fortiscare V3], Omnis Health [Embrace Talk], Prodigy [Prodigy Autocode, Prodigy Voice], Relion Premier Voice). If none are formulary, approve. **Note**: This is not an all-inclusive list of blood glucose meters with audio capabilities. **Note**: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **4.** Individuals using an insulin pump/meter system that is not compatible with one of the available formulary alternatives: approve. **5.** If the request is for Freestyle Precision Neo strips for use in a Freestyle Libre reader, approve.
diclofenac epolamine 1.3% topical patch (authorized generic of Flector Patch) PID: 66284	diclofenac epolamine 1.3% topical patch	**1.** Direct the individual to use Flector patch (brand), if formulary. If Flector patch (brand) is non-formulary, approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Licart 1.3% topical system, Pennsaid 2.0% topical solution (pump), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the individual has tried over-the-counter Voltaren 1% gel.
Dipentum PID: 13775	olsalazine capsule	**1.** Approve if the individual has tried two products from the following list (if two are formulary, or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), sulfasalazine (generics), mesalamine delayed-release tablets (Lialda, generics), Delzicol, balsalazide (Colazal, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. If none are formulary, approve.
Divigel PID: 13746	estradiol gel 0.1%	**1.** Approve if the individual has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, Estrogel, if one is formulary. If none of these are formulary, then approve if the individual has tried one estradiol patch (e.g., Alora, estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics).
Doral and authorized generic PID: 82077	quazepam tablets	**1.** Approve if the individual has tried estazolam or lorazepam, if formulary. If neither are formulary, approve.
Doryx DR 80 mg and authorized generic	doxycycline hyclate delayed-release tablets	**1.** Direct individual to other doxycycline products. An approval can be provided if, per the prescriber, the 80 mg tablet is required to meet the prescribed dosing requirement.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
PID: 90927		
Doryx MPC PID: 99529	doxycycline hyclate tablet, delayed-release	**1.** Direct individual to other doxycycline products.
doxycycline 40 mg capsules (authorized generic of Oracea) PID: 13063	doxycycline 40 mg capsules	Rosacea. **1.** Approve if the individual meets both of the following (A and B): A. Individual has tried two of the following: 1) a topical metronidazole-containing product 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Individual has tried one other generic, oral doxycycline product.
Drizalma Sprinkle PID: 76000	duloxetine delayed-release capsules	**1.** Approve if the individual has tried one product from the following list (if one is formulary): duloxetine capsules (Cymbalta, generics), Fetzima, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], venlafaxine ER capsules (Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **NOTE:** If individual has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the individual is unable to swallow, has difficulty swallowing, or requires administration via a nasogastric tube.
Drysol PID: 91403	aluminum chloride 20% topical solution	Hyperhidrosis in the axillae, palms, or soles. **1.** Approve if the individual has tried one over-the-counter aluminum-containing product (such as Certain Dri, Bromi-lotion).
Duaklir Pressair PID: 74655	aclidinium bromide and formoterol fumarate inhalation powder	**1.** Approve if the individual has tried three of Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat, if three are formulary, or two if two are formulary or one if one is formulary. **2.** If the individual is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the individual has tried Anoro Ellipta, if formulary. If Anoro Ellipta is non-formulary, approve. **3.** If none of the LAMA/LABA combination inhalers are formulary, approve if the individual has tried one formulary single-entity long-acting beta-agonist (LABA) inhaler: Serevent Diskus or Striverdi Respimat AND one formulary single-entity long-acting muscarinic antagonist (LAMA) inhaler: Incruse Ellipta, Spiriva HandiHaler, Spiriva Respimat, or Tudorza Pressair. If there are no formulary single-entity LABAs, approve. If there are no formulary single-entity LAMAs, approve.
Durlaza PID: 52875	aspirin extended-release capsules	**1.** Approve if the individual has tried and cannot take two other single-entity oral aspirin products.
Dutoprol PID: 13632	metoprolol succinate extended-release/HCTZ tablets	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with metoprolol-HCTZ (immediate-release) tablets. **2.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with metoprolol succinate extended-release tablets (Toprol XL, generics) AND hydrochlorothiazide (HCTZ) taken concomitantly.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Dxevo dose pack PID: 59120	dexamethasone 1.5 mg tablets (11-day pack)	**1.** The individual is directed to use the dexamethasone 1.5 mg tablets (not packed as dose packs). If dexamethasone 1.5 mg tablets (not packaged as dose packs) are non-formulary, approve. Approval duration: 14 days
Ecoza foam PID: 87740	econazole nitrate topical foam	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Edarbi PID: 13726	azilsartan	**1.** Approve if the individual has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve. **2.** Individuals recently hospitalized (and discharged within 30 days) for a cardiovascular event (e.g., myocardial infarction [MI], hypertensive emergency) who has already been started and stabilized on Edarbi: approve.
Edarbyclor PID: 13633	azilsartan and chlorthalidone tablets	**1.** Approve if the individual has tried five of the following formulary angiotensin receptor blocker/diuretic combination products, if five are formulary, or four if four are formulary, or three if three are formlary, or two are formulary, or one if only one is formulary): candesartan-hydrochlorothiazide (Atacand HCT, generics), irbesartan-hydrochlorothiazide (Avalide, generics), losartan-hydrochlorothiazide (Hyzaar, generics), telmisartan-hydrochlorothiazide (Micardis HCT, generics), valsartan-hydrochlorothiazide (Diovan HCT, generics), olmesartan-hydrochlorothiazide (Benicar HCT, generics). **2.** Approve if the individual has tried chlorthalidone AND Edarbi, if Edarbi is formulary. If Edarbi is non-formulary, approve if the individual has tried five of the following formulary angiotensin receptor blockers (ARBs), if five are formulary or four if four are formulary or three if three are formulary, or two if only two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve.
Elestrin PID: 13727	estradiol gel 0.06%	**1.** Approve if the individual has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, Estrogel, if one is formulary. If none of these are formulary, then approve if the individual has tried one estradiol patch (e.g., Alora, estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics).
Elyxyb PID: 100294	celecoxib oral solution	Acute treatment of migraine. **1.** Direct the individual to celecoxib capsules. If celecoxib capsules (Celebrex, generics) are non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Emend oral suspension PID: 55997	aprepitant oral suspension	**1.** Approve if the individual has tried one formulary alternative from the following list: aprepitant capsules (Emend, generics) or Varubi tablets. If none are formulary, approve. **2.** Individuals ≥ 12 and <18 years of age: approve if the individual has tried aprepitant capsules (Emend, generics), if formulary. If aprepitant capsules (Emend, generics) are non-formulary, approve. **3.** Individuals < 12 years of age: approve. **4.** Individuals who cannot swallow or have difficulty swallowing capsules, approve. **5.** Approve if the individual has already started Emend oral suspension to complete all cycles in the current course of chemotherapy.
Emflaza PID: 58808	deflazacort tablets and oral suspension	See standard *Muscular Dystrophy – Emflaza Prior Authorization Policy criteria.*
Envarsus XR PID: 52375, 52607	tacrolimus extended-release tablets	**1.** Approve if the individual has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** Approve if the individual has the CYP3A5*1 allele. Note: The CYP3A5*1 allele is a gene variant determined by testing that may confer faster metabolism of certain medications. **3.** If the individual has already started on therapy with Envarsus XR, approve.
Epaned PID: 33837	enalapril maleate powder for oral solution, enalapril maleate oral solution	**1.** Approve if the individuals has tried enalapril tablets (Vasotec, generics), if formulary. If enalapril tablets (Vasotec, generics) are non-formulary, approve. **2.** Approve if the individual cannot swallow or has difficulty swallowing tablets.
epinephrine auto-injector PID: 49037	epinephrine 0.15 mg, 0.3 mg auto-injector authorized generic (Amneal Pharmace, Avkare, A-S Medication)	**1.** Approve if the individual has tried one product from the following list, if one is formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve.
Eprontia PID: 100295	topiramate oral solution	**1.** Approve if the individual has tried and cannot take topiramate sprinkle capsules (Topamax Sprinkle capsules), if formulary. If topiramate sprinkle capsules (Topamax Sprinkle capsules) are non-formulary, approve.
Ertaczo PID: 101356 **Effective 7/1/2022**	sertaconazole nitrate 2% cream	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ecoza foam, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Esgic capsule	butalbital 50 mg, acetaminophen 325	**1.** Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
PID: 58422	mg, caffeine 40 mg capsule or tablet	butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
esomeprazole strontium PID: 83331	esomeprazole strontium 49.3 mg capsules	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics).
Estring PID: 94573	estradiol 2 mg vaginal ring	**1.** Approve if the individual has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Femring vaginal ring, Premarin Cream, estradiol 0.01% cream (Estrace Cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the individual requires a low-dose vaginal product, approve if the individual has tried one of Imvexxy vaginal insert or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.
Estrogel PID: 13717	estradiol gel 0.06%	**1.** Approve if the individual has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, Estrogel, if one is formulary. If none of these are formulary, then approve if the individual has tried one estradiol patch (e.g., Alora, estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics).
Evamist PID: 13728	estradiol transdermal spray	**1.** Approve if the individual has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, Estrogel, if one is formulary. If none of these are formulary, then approve if the individual has tried one estradiol patch (e.g., Alora, estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics).
Exelderm and authorized generic (sulconazole nitrate 1%) [Authorized generic only] PID: 79067	sulconazole nitrate 1% (cream and solution)	**1.** Approve if the individual has tried four topical antifungals (e.g., naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra [over-the-counter {OTC}], clotrimazole 1% cream [OTC formulation], econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam [Extina, generics], Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, ciclopirox 0.77% cream or gel [generics], Luzu 1% cream, Mentax 1% cream, Xolegel 2% gel).
Extavia PID: 13538	interferon beta-1b injection	**1.** Approve if the individual has tried three formulary products from the following list: Betaseron, Rebif, Avonex, or Plegridy **[documentation required]**, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the individual has been established on Extavia for greater than or equal to 120 days, direct to Betaseron. If Betaseron is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Ezallor Sprinkle PID: 71962	rosuvastatin capsules	**1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), pitavastatin (Livalo, Nikita, Zypitamag), pravastatin (Pravachol), Livalo, or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Individuals who cannot swallow or have difficulty swallowing tablets or capsules, approve.
Fabior and authorized generic [Authorized generic only] PID: 33838 **Effective 7/1/2022: Brand and authorized generic**	tazarotene 0.1% foam	Other diagnoses (e.g., acne vulgaris). Approve if the individual meets the following (A and B): A. Individual has tried one of tazarotene cream (Tazorac cream, generics) or Tazorac gel, if one is formulary. If none are formulary, approve; AND B. Individual has tried a topical tretinoin-containing product. Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics). Psoriasis. Approve if the individual has tried one of tazarotene cream (Tazorac cream, generics) or Tazorac gel, if one is formulary. If none are formulary, approve.
Femring PID: 13745	estradiol vaginal ring (0.05 mg and 0.10 mg)	**1.** Approve if the individual has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Premarin cream, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), Alora patch, estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), Menest tablets, or Premarin tablets. If none are formulary, approve.
Fenoprofen capsules [brand] PID: 63053	fenoprofen capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** For example: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Fenortho PID: 63054	fenoprofen capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** For example: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Five unique NSAIDs should be tried.
Fensolvi PID: 83005	leuprolide acetate for injectable suspension	**1.** Approve if the individual has tried both Lupron Depot-Ped and Triptodur, if formulary, or try one if one is formulary. If neither are formulary, approve. **2.** Gender-dysphoric/gender-incongruent persons; persons undergoing gender reassignment (female-to-male or male-to-female), approve if the individual has tried Lupron Depot-Ped, if formulary. If Lupron Depot-Ped is non-formulary, approve.
Fexmid PID: 49780	cyclobenzaprine tablet	**1.** Approve if the individual has tried and cannot take cyclobenzaprine tablets (generics), if formulary. If cyclobenzaprine tablets (generics) are non-formulary, approve.
Fiasp PID: 60765	insulin aspart injection vial, pen, cartridge	Approve if the individual meets the following (1 or 2): **1.** Individual meets the following (A, B, and C): A. Individual has tried Apidra, if formulary; AND B. Individual has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Admelog; AND Note: A previous trial of Lyumjev would satisfy this requirement. C. Individual has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog); OR **2.** Individual is using an insulin pump that is not compatible with the formulary alternative(s), approve. Note: If no products in A, B, or C are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).
Fintepla PID: 85180	fenfluramine oral solution	See standard *Antiepileptics – Fintepla Prior Authorization Policy criteria.*
Fioricet capsule PID: 58422	butalbital 50 mg, acetaminophen 300 mg, caffeine 40 mg capsule or tablet	**1.** Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Fiorinal capsule PID: 58422	butalbital 50 mg, aspirin 325 mg, caffeine 40 mg capsule	1. Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Firazyr PID: 98800	icatibant injection for subcutaneous use	**1.** See standard *Hereditary Angioedema – Icatibant Preferred Specialty Management Policy* criteria.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Firvanq PID: 61982	vancomycin oral solution	**1.** Approve if the individual has tried vancomycin capsules (Vancocin oral capsule, generics) or vancomycin oral solution (Vancocin oral solution, generics), if formulary. If neither are formulary, approve. **2.** If the individual is unable to swallow or has difficulty swallowing capsules, approve if the individual has tried vancomycin oral solution (Vancocin oral solution, generics), if formulary. If vancomycin oral solution is non-formulary, approve.
Flarex PID: 13249	fluorometholone acetate ophthalmic suspension 0.1%	**1.** Approve if individual has tried three formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), FML Forte/S.O.P., Inveltys, difluprednate (Durezol, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the individual has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the individual has tried one of the following, if one is formulary: fluorometholone (FML Liquifilm, generics), FML Forte/S.O.P., Inveltys, loteprednol etabonate (Lotemax, generics), Lotemax SM, or difluprednate (Durezol, generics). If none are formulary, approve.
Fleqsuvy PID: 102580	baclofen oral suspension, concentrated formulation	**1.** Direct to oral baclofen tablets. **2.** Individual is unable to or has difficulty swallowing oral tablets, approve if the individual has tried one of Ozobax solution or Lyvispah oral gransules, if formulary. If neither are formulary, approve.
Flowtuss PID: 52322	hydrocodone bitartrate/ guaifenesin oral solution	**1.** Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine/guaifenesin oral solution (generics), Guaifenesin AC syrup, guaifenesin with codeine syrup (generics), Mar-Cof CG liquid, M-Clear WC liquid, Ninjacof XG liquid, Virtussin AC liquid, Obredon solution. If none are formulary, approve if the individual has tried two other prescription or over-the-counter (OTC) cough and cold products.
fluticasone propionate/salmeterol multidose dry powder inhaler PID: 59644	fluticasone propionate/salmeterol inhalation powder (authorized generic to AirDuo RespiClick)	**1.** Approve if the individual has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Advair HFA, fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), AirDuo RespiClick, AirDuo Digihaler, Breo Ellipta, Dulera or Symbicort. If none are formulary, approve. **2.** Individuals who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), AirDuo RespiClick, AirDuo Digihaler, or Breo Ellipta. If none are formulary, approve. **3.** Individuals < 18 years of age: approve if the individual has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): Symbicort, Advair HFA, fluticasone propionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), AirDuo RespiClick, AirDuo Digihaler, or Dulera. If none are formulary, approve. **4.** Individuals < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried one of fluticasone propionate/salmeterol inhalation powder, Wixela

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		(Advair Diskus, generics), AirDuo RespiClick, or AirDuo Digihaler, if formulary. If neither are formulary, approve. **Note**: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. AirDuo RespiClick and AirDuo Digihaler count as one alternative.
FML Forte PID: 13247	fluorometholone 0.25% ophthalmic suspension	**1.** Approve if individual has tried three formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), FML S.O.P., Flarex, Inveltys, difluprednate (Durezol, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the individual has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the individual has tried one of the following, if one is formulary: loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), FML S.O.P., Flarex, or difluprednate (Durezol, generics). If none are formulary, approve.
FML S.O.P. PID: 13248	fluorometholone ophthalmic ointment 0.1%	**1.** Approve if individual has tried two formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, Inveltys, difluprednate (Durezol, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Approve if the individual has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the individual has tried one of the following, if one is formulary: loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, or difluprednate (Durezol, generics). If none are formulary, approve.
Follistim AQ PID: 13280	follitropin beta	**1.** Approve if the individual has tried one product from the following list: Gonal-F/Gonal-F RFF, if formulary. If Gonal-F/Gonal-F RFF is non-formulary, approve. **2.** Individual has been started on a current cycle of therapy with Follistim AQ: approve to complete the current cycle.
Forfivo XL and authorized generic PID: 16542 **Effective 7/1/2022**	bupropion hydrochloride extended-release tablets	**1.** Individual is directed to bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics). If bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics) are non-formulary, approve.
Fosrenol oral powder PID: 13310	lanthanum carbonate oral powder	**1.** Approve if the individual has tried two formulary alternatives from the following list (if two are formulary or one if one is formulary): sevelamer hydrochloride tablets (Renagel, generics), Velphoro chewable tablets, Auryxia tablets, Phoslyra, or sevelamer carbonate tablets/powder for oral suspension (Renvela, generics). If none are formulary, approve. **2.** Individuals who are unable to chew and swallow tablets: approve if the individual has tried sevelamer carbonate powder for oral suspension

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		(Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.
Fotivda PID: 94007	tivozanib capsules	Renal Cell Carcinoma. Approve if the individual meets one of the following (1, 2, or 3): **1.** Individual has tried one of Inlyta, Lenvima, or Cabometyx. If none are formulary, approve; OR **2.** If there are toxicity concerns with a trial of Lenvima (and other concomitantly given medications), according to the prescriber, approve if the individual has tried Inlyta or Cabometyx. If neither are formulary, approve; OR **3.** Individual has already been started on therapy with Fotivda.
Gimoti PID: 88700	metoclopramide nasal spray	**1.** No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Gimoti. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)
Glumetza PID: 13771	metformin extended-release tablets	**1.** Approve if the individual has tried BOTH one metformin immediate-release tablet product AND two other formulary metformin extended-release products (if two are formulary or one if one is formulary): metformin extended-release tablets, Fortamet (brand or generic), or Riomet ER. **NOTE:** A trial of Glumetza would NOT count toward this requirement.
Gocovri ER PID: 61361	amantadine extended-release capsules	**1.** Approve if the individual has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND experienced inadequate efficacy or intolerability with the product.
Golytely packets PID: 91755	polyethylene glycol; electrolytes powder for solution	**1.** Direct to peg-electrolyte solution (Golytely, generics) [not in packet form]. Approval duration: 1 month
Granix PID: 38885	tbo-filgrastim injection	**1.** Approve if the individual meets BOTH of the following (a and b): a. Individual has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Releuko, Neupogen, Nivestym, or Zarxio **[documentation required];** AND Note: If none are formulary, approve. b. Individual cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Individuals requiring a dose < 180 mcg: approve if the individual meets the following (a and b): a. Individual has tried one of Releuko, Neupogen, or Nivestym **[documentation required],** if formulary; AND Note: If none are formulary, approve. b. Individual cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **3.** Individuals who initiated therapy with Granix and requires further medication to complete the current cycle of chemotherapy: approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Helidac PID: 86204	bismuth subsalicylate chewable tablets, metronidazole tablets, tetracycline capsules	**1.** Approve if the individual meets ONE of the following (A or B): **A.** The individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth subcitrate + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]); OR **B.** The individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance to any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole (Prevpac, generics), Omeclamox-Pak, Talicia, Pylera). Approval duration: 1 month
Hemady PID: 90925, 90926	dexamethasone 20 mg tablets	**1.** Approve if the individual has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.
Hemangeol PID: 44694 **Effective 7/1/2022**	propranolol hydrochloride 4.28 mg/mL oral solution	Proliferating infantile hemangioma. **1.** Approve if the individual has tried propranolol hydrochloride oral solution (20 mg/5mL) [NOT Hemangeol].
Humatrope PID: 24536	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: **1.** Approve if the individual has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton. If none are formulary, approve.
Hycofenix PID: 52327	hydrocodone/ pseudophedrine/ guaifenesin oral solution	1. Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): Tusnel C syrup, Virtussin DAC liquid. If none are formulary, approve if the individual has tried two other prescription or over-the-counter (OTC) cough and cold products.
Ibsrela PID: 103614	tenapanor tablets	**1.** Female individuals: Approve if the individual has tried three products from the following list: Amitiza, Linzess, or Trulance, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** Male individuals: Approve if the individual has tried both Linzess and Trulance, if both are formulary (or one if only one is formulary). If neither are formulary, approve. Note: A male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression). A female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Ilumya PID: 61984	tildrakizumab SC injection	**1.** See Inflammatory Conditions - Ilumya PSM Policy criteria
Impeklo PID: 90572	clobetasol propionate lotion, 0.05%	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, desonide, betamethasone, clobetasol, fluocinonide, halobetasol, mometasone, halcinonide, diflorasone. NOTE: The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).
Impoyz PID: 101357 **Effective 7/1/2022**	clobetasol propionate cream, 0.025%	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide, diflorasone. NOTE: The products must be chemically unique.
Imvexxy PID: 63202	estradiol vaginal insert	**1.** Approve if the individual has tried two formulary alternatives from the following list (or one if only one is formulary): Premarin vaginal cream, Femring vaginal ring, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the individual requires a low-dose vaginal product, approve if the individual has tried one of Estring or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.
Inderal XL PID: 87741	propranolol hydrochloride capsule, extended release	**1.** Direct the individual to propranolol extended-release capsules. If propranolol extended-release capsules are non-formulary, approve.
Indocin Suppositories PID: 99945 **Effective 7/1/2022**	indomethacin suppositories	**1.** No exceptions are recommended. There are multiple therapeutic alternatives available. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are multiple therapeutic alternatives available.)
Indocin Suspension PID: 65916 **Effective 7/1/2022**	indomethacin oral suspension	**1.** Approve if the individual has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics), if formulary. If neither are formulary, approve. **NOTE:** Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Innopran XL PID: 87741	propranolol hydrochloride capsule, extended release	**1.** Direct the individual to propranolol extended-release capsules. If propranolol extended-release capsules are non-formulary, approve.
Insulin Glargine-YFGN (authorized generic of Semglee) PID: 98954	insulin glargine U-100 vial and pen	**1.** Individual is directed to use Semglee (YFGN) [brand], if formulary. If Semglee (YFGN) [brand] is non-formulary, approve if the individual has tried one of Lantus or Basaglar, if formulary. If Lantus and Basaglar are non-formulary, approve.
Inqovi PID: 86139	decitabine and cedazuridine tablets	Chronic Myelomonocytic Leukemia; Myelodysplastic Syndromes (Note: Examples of myelodysplastic syndromes include: refractory anemia, refractory anemia with ringed sideroblasts, and refractory anemia with excess blasts.). **1.** Approve if the individual has tried decitabine injection (Dacogen, generics), if formulary. If decitabine injection (Dacogen, generics) is non-formulary, approve. **2.** Approve if the individual is unable to obtain and/or maintain intravenous access. **3.** Approve if the individual has already started therapy with Inqovi.
Inrebic PID: 72625	febratinib capsules	Myelofibrosis; Myeloid/Lymphoid Neoplasms with Eosinophilia: **1.** Approve if the individual has tried Jakafi, if formulary. If Jakafi is non-formulary, approve. **2.** Approve if the individual has already been started on Inrebic.
Insulin Lispro JR PID: 66361	Insulin lispro JR	**1.** Direct the individual to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve.
Insulin Lispro Mix 75/25 PID: 83326	75% Insulin lispro protamine/25% insulin lispro Kwikpen	**1.** Direct the individual is Humalog 75/25 (brand), if formulary. If Humalog 75/25 (brand) is non-formulary, approve if the individual has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix, if formulary. If neither are formulary, approve.
Intrarosa PID: 59989	prasterone vaginal inserts	**1.** Approve if the individual has tried one formulary alternative from the following list: Imvexxy vaginal ring, Femring vaginal ring, Premarin Cream, Estring vaginal ring, estradiol 0.01% cream (Estrace cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** Approve if, according to the prescriber, the individual is at an increased risk of endometrial cancer, stroke, or deep vein thrombosis (DVT).
Invokamet PID: 47593	canagliflozin and metformin tablets	**1.** Approve if the individual has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet XR, Synjardy, Synjardy XR, Segluromet, or Xigduo XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if only one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Invokamet XR PID: 57340	canagliflozin and metformin extended-release tablets	**1.** Approve if the individual has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet (not XR), Synjardy, Synjardy XR, Xigduo XR, or Segluromet. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.
Invokana PID: 42073	canagliflozin tablets	**1.** Approve if the individual has tried three formulary alternatives from the following list (or two if two are formulary or one if only one is formulary): Farxiga, Steglatro, or Jardiance. If none are formulary, approve. **2.** If Invokana is being used for glycemic control and the individual's estimated glomerular filtration rate is less than 45 mL/minute, approve if the individual has tried Jardiance, if formulary. If Jardiance is non-formulary, approve. **3.** If the individual has diabetic kidney disease, approve if the individual has tried Farxiga, if formulary. If Farxiga is non-formulary, approve. **4.** If the individual, according to the prescriber, has established cardiovascular disease OR at least two risk factors for cardiovascular disease, approve if the individual has tried Jardiance and Farxiga, if formulary. If neither are formulary, approve.
Isturisa PID: 82447	osilodrostat tablets	Cushing's Disease in an individual ≥ 18 years of age. Approve if the individual meets one of the following (A or B): A. Individual has tried one of Signifor or Signifor LAR. If neither are formulary, approve; OR B. Individual has already been started on Isturisa. Endogenous Cushing's Syndrome in an individual ≥ 18 years of age. Approve if the individual meets one of the following (A or B): A. Individual has tried one of Signifor, Signifor LAR, ketoconazole, Metoprione (metyrapone capsules), Lysodren (mitotane tablets), Recorlev, or Korlym. If none are formulary, approve; OR B. Individual has already been started on Isturisa. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product.
Jentadueto PID: 13673	linagliptin and metformin tablets	**1.** Approve if the individual has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto XR, alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, Kombiglyze XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, generics), Tradjenta, Onglyza, or Januvia. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Individuals with a history of heart failure (HF) or renal impairment: approve if the individual has tried ONE of Jentadueto XR, Janumet or Janumet XR, if one is formulary. If none are formulary, approve if the individual has tried

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics).
Jentadueto XR PID: 55506	linagliptin and metformin extended-release tablets	**1.** Approve if the individual has tried three metformin-DPP-4 inhibitor combination products from the following list: (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto (NOT XR), alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, Kombiglyze XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, generics), Tradjenta, Onglyza, or Januvia. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Individuals with a history of heart failure or renal impairment: approve if the individual has tried one of Jentadueto (NOT XR), Janumet or Janumet XR, if formulary**.** If **n**one are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics).
Kapspargo Sprinkle PID: 63208	metoprolol succinate extended-release capsules	**1.** Approve if the individual has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve. **2.** If the individual requires a dosage form which can be opened and sprinkled for alternative administration (e.g., for individuals unable to swallow capsules, for nasogastric tube administration), approve.
Katerzia PID: 73651	amlodipine oral suspension	**1.** Direct the individual to amlodipine tablets. **2.** If the individual is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the individual has tried Norliqva oral solution, if formulary. If Norliqva oral solution is non-formulary, approve.
Kazano PID: 24615	alogliptin and metformin tablets	**1.** Approve if the individual has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto, Jentadueto XR, Janumet, Janumet XR, Kombiglyze XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin tablets (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Jentadueto and Jentadueto XR would count as one alternative. Janumet and Janumet XR would count as one alternative.
Kevzara PID: 59410	sarilumab subcutaneous injection	**1.** See Inflammatory Conditions - Kevzara PSM Policy criteria
Kineret PID: 13644	anakinra SC injection	**1.** See Inflammatory Conditions - Kineret PSM Policy criteria
Klisyri PID: 91816	tirbanibulin ointment 1%	**1.** Approve if the individual has tried two of the following products: diclofenac 3% gel (Solaraze, generics), a fluorouracil-containing product (e.g., fluorouracil cream, Carac, fluorouracil topical solution), or an imiquimod-containing product (e.g., imiquimod 5% cream, Aldara, Zyclara).
Kombiglyze XR PID: 13669	saxagliptin plus metformin extended-release tablets	**1.** Approve if the individual has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, Janumet, Janumet XR. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, generics), Onglyza, Tradjenta, or Januvia. If none are formulary, approve if the individual has tried metformin (Glucophage, Glucophage ER, generics). **Note**: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. Janumet and Janumet XR would count as one alternative.
Korlym PID: 13785	mifepristone 300 mg tablets	Endogenous Cushing's Syndrome in an individual ≥ 18 years of age. Approve in individuals who meet the following criteria (A and B): A. Korlym is being used to control hyperglycemia secondary to hypercortisolism in individuals who have type 2 diabetes mellitus or glucose intolerance; AND B. The individual meets ONE of the following (1 or 2): 1. Individuals have tried one product from the following list : ketoconazole tablets, Recorlev, Isturisa, Metopirone capsules, Signifor/Signifor LAR injection, or Lysodren tablets. If none are formulary, approve; OR Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. 2. The individual has already been started on Korlym therapy.
Lampit PID: 87488	nifurtimox tablets	**1.** Approve if the individual has tried benznidazole, if formulary. If benznidazole is non-formulary, approve. **2.** Approve if the individual is less than 2 years of age. **3.** Approve if the individual has already started on therapy with Lampit.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Lantus PID: 13720	insulin glargine U-100 vial and SoloStar device	**1.** Individual is directed to use Semglee (YFGN) or Insulin glargine-YFGN (authorized generic of Semglee (YFGN), if formulary. If neither are formulary, approve. **2.** Approve if the individual has tried and cannot use Semglee-YFGN or Insulin glargine-YFGN due to a formulation difference in the inactive ingredient (s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.
Lastacaft PID: 62936	alcaftadine ophthalmic solution	**1.** Approve if the individual has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), olopatadine solution (generics), or Zerviate. If none are formulary, approve.
ledipasvir / sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni) PID: 64670	ledipasvir/sofosbuvir tablets 90 mg/400 mg	**1.** Individual is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve. Approval duration: 24 weeks
levalbuterol HFA inhaler PID: 31376	levalbuterol inhalation aerosol (authorized generic)	**1.** Approve if the individual has tried one formulary albuterol containing inhaler from the following list: albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (ProAir HFA, generics), ProAir Respiclick, ProAir Digihaler, if one is formulary. If none are formulary, approve. **2.** Individuals < 12 years of age or individuals who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the individual has tried one product from the following list (if one is formulary): albuterol HFA (ProAir HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), or albuterol HFA (Proventil HFA, generics). If none are formulary, approve.
Lexette and halobetasol propionate 0.05% topical foam PID: 105808 **Effective 7/1/2022**	halobetasol propionate topical foam 0.05%	**1.** Approve if the individual has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.
Lispro (authorized generic to Humalog) PID: 66361	Insulin lispro vial/Kwikpen	Direct the individual to brand Humalog, if formulary. If brand Humalog is non-formulary, approve if the individual meets the following (1 or 2): **1.** Individual meets the following (A, B, and C): A. Individual has tried Apidra, if formulary; AND B. Individual has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND C. Individual has tried Admelog, if formulary; OR **2.** Individual is using an insulin pump that is not compatible with the formulary alternative(s), approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: If no products in A, B, or C are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Fiasp vial, Fiasp Flextouch, Fiasp penfil would all count as one alternative).
Lo Loestrin FE PID: 91405	ethinyl estradiol 0.01 mg; norethindrone acetate 1 mg; ferrous fumarate tablet	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried two other oral contraceptive agents; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Lofena and authorized generic diclofenac potassium [Authorized generic only] PID: 99946	diclofenac potassium tablets	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDS. **Note:** Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Loreev XR PID: 98552	lorazepam extended-release capsules	**1.** Direct the individual to use lorazepam tablets.
Lorzone PID: 49781	chlorzoxazone tablets	Approve if the individual has tried and cannot take generic chlorzoxazone tablets, if formulary. If generic chlorzoxazone tablets are non-formulary, approve.
Lucemyra PID: 62539	lofexidine tablets	**2.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with clonidine.
Lupkynis PID: 92522	voclosporin capsules	Lupus nephritis: **1.** Approve if the individual meets ONE of the following (a or b): a) The medication is being used concurrently with mycophenolate mofetil and a systemic corticosteroid; OR b) According to the prescriber, individual is not a candidate for mycophenolate mofetil and a systemic corticosteroid due to inadequate efficacy OR significant intolerance with these medications. **2.** Approve if the individual has already been started on Lupkynis.
Luzu and authorized generic (luliconazole 1% cream) [Authorized generic only] PID: 41732	luliconazole 1% cream	**1.** Approve if the individual has tried four topical antifungals (e.g., naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra [over-the-counter {OTC}], clotrimazole 1% cream [OTC formulation], econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam [Extina, generics], Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel [generics], Mentax 1% cream, Xolegel 2% gel).
Lybalvi	olanzapine and samidorphan tablets	**1.** Approve if the individual has tried two oral antipsychotics (e.g., olanzapine tablets, aripiprazole tablets [Abilify, generics], Fanapt tablets, ziprasidone

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
PID: 98251		capsules [Geodon, generics], paliperidone ER tablets [Invega, generics], risperidone tablets/orally disintegrating tablets [ODT] {Risperdal, generics}, asenapine sublingual tablets [Saphris, generics], quetiapine tablets [Seroquel, generics], quetiapine extended-release tablets [Seroquel XR, generics], Rexulti tablets, Vraylar capsules, olanzapine tablets/ODT [Zyprexa/Zydis, generics], Caplyta). **2.** Approve if the individual is currently taking Lybalvi. **3.** Approve if the individual has taken Lybalvi at any time in the past.
Mavyret PID: 59892	glecaprevir/ pibrentasvir tablets	**1.** See *Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) Policy* Approval duration: Up to 16 weeks
Maxidex PID: 62930	dexamethasone 0.1% ophthalmic suspension	**2.** Approve if the individual has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary or one if one is formulary): dexamethasone (generics), difluprednate (Durezol, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), FML Forte/S.O.P., Flarex, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild. If none are formulary, approve. **3.** If the individual has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the individual has tried one product from the following list (if one is formulary): fluorometholone (FML Liquifilm, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, Flarex, FML Forte/S.O.P., or difluprednate (Durezol, generics). If none are formulary, approve.
Menest PID: 94574	esterified estrogens tablets	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: estradiol tablets (Estrace, generics) and Premarin tablets. If neither are formulary, approve.
Mulpleta PID: 63680	lusutrombopag tablets	**1.** Approve if the individual has tried Doptelet, if formulary. If Doptelet is non-formulary, approve. **2.** Approve if the individual has already started a course of therapy with Mulpleta in order to finish the course. Approval duration: 1 month
Mycapssa PID: 87489	octreotide delayed-release capsules	<u>Acromegaly.</u> **1.** Approve if the individual has tried one of Sandostatin LAR, Somatuline Depot, lanreotide subcutaneous injection, or Signifor LAR, if formulary. If none are formulary, approve. **2.** Individuals with diabetes: Individuals with diabetes: approve if the individuals has tried one of Sandostatin LAR Depot, lanreotide subcutaneous injection, or Somatuline Depot, if formulary. If none are formulary, approve.
Mytesi PID: 87742	crofelemer delayed-release tablets	**1.** For the symptomatic relief of non-infectious diarrhea in adult individuals with Human immunodeficiency virus (HIV) or Acquired immunodeficiency syndrome (AIDS): Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both diphenoxylate-atropine tablets AND loperamide.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Nalfon PID: 63055	fenoprofen capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** Examples include: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Natazia PID: 91406	dienogest; estradiol valerate tablet	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried four other oral contraceptive agents; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Nesina and authorized generic PID: 23796	alogliptin tablets	**1.** Approve if the individual has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Onglyza, Tradjenta, or Januvia. If none are formulary, approve.
Neulasta PID: 63204	pegfilgrastim injection	**1.** Approve if the individual meets BOTH of the following (a and b): **a.** The individual has tried four of the following, if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Fulphila, Udenyca, Ziextenzo, or Nyvepria; AND Note: If none are formulary, approve. **b.** Individual cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Individuals who have initiated therapy with Neulasta and requires further medication to complete the current cycle of chemotherapy: approve.
Nevanac PID: 13783	nepafenac ophthalmic suspension 0.1%	**1.** Approve if the individual has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Ilevro, Prolensa, BromSite or bromfenac 0.09% ophthalmic solution (generics). If none are formulary, approve. **2.** Individuals with a sulfite allergy: approve if the individual has tried two of the following, if two are formulary (or one if only one is formulary): BromSite, diclofenac ophthalmic solution (generics), Ilevro, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Individuals < 18 years of age: approve if the individual has tried ketorolac ophthalmic solution (Acular, Acular LS, generics) or Ilevro, if one is formulary. If neither are formulary, approve.
Nexiclon XR PID: 103845	clonidine ER tablet	**1.** Approve if the individual tried and is unable to use both clonidine immediate-release tablets AND clonidine transdermal patches.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Nexium packet (granules for oral suspension) 5 mg and 2.5 mg packets PID: 13788	esomeprazole delayed-release granules for oral suspension (packet)	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Individuals < 18 years of age OR individuals who have difficulty swallowing tablets/capsules: Approve if the individual has tried two proton pump inhibitors (PPIs). **3.** Individuals < 1 year of age: approve if the individual has tried Prilosec DR suspension, if formulary. If Prilosec DR suspension is non-formulary, approve. **Note:** The requested agent would NOT count as a trial of an alternative.
Nextstellis PID: 95079	estetrol and drospirenone tablets	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried four other oral contraceptive agents; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Noctiva PID: 61860	desmopressin acetate nasal spray for intranasal use	Nocturia due to Nocturnal Polyuria. Approve for 1 year if the individual meets all of the following criteria (A, B, C, D, E, F, G and H): **A.** Individual is ≥ 50 years of age; AND **B.** The diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection before treatment initiation and the individual meets one of the following (i or ii): i. The nocturnal urine volume exceeds 20% of the total 24-hour urine volume in individuals < 65 years of age; OR ii. The nocturnal urine volume exceeds 33% of the total 24-hour urine volume in individuals ≥ 65 years of age; AND **C.** Prior to desmopressin therapy, individual awakens at least two times per night to void; AND **D.** Individual has serum sodium concentrations within the normal range (135 to 145 mmol/L); AND **E.** Prescriber has verified that the individual does not have the following conditions/circumstances in which use of Noctiva is not recommended (i, ii, iii, iv, v, or vi): i. Currently receiving loop diuretics (e.g., furosemide, torsemide, bumetanide); OR ii. Currently receiving systemic or inhaled glucocorticoids; OR iii. Renal impairment with an estimated glomerular filtration rate < 50 mL/min/1.73 m2; OR iv. New York Heart Association class II to IV congestive heart failure; OR v. Polydipsia; OR vi. Known or suspected syndrome of inappropriate antidiuretic hormone secretion; AND **F.** Individual has tried non-pharmacologic techniques or lifestyle interventions to manage the nocturia; AND

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Examples of non-pharmacologic techniques include nighttime fluid restriction, avoidance of caffeine and alcohol, earlier timing of medications, leg elevation, or use of compression stockings. **G.** Individual tried one of Nocdurna (desmopressin acetate sublingual tablets) or oral desmopressin acetate tablets (DDAVP tablets, generics); AND **H.** Noctiva is prescribed by or in consultation with a urologist, geriatrician, or endocrinologist.
Noritate PID: 13303 **Effective 7/1/2022**	metronidazole cream 1%	**1.** Direct the individual to a topical metronidazole product. Examples of topical metronidazole products include metronidazole 0.75% cream (MetroCream, generics), metronidazole 0.75% or 1% gel (Metrogel, generics), metronidazole 0.75% lotion (MetroLotion, generics).
Northera and generic droxidopa capsules PID: 46737	droxydopa capsules	Neurogenic Orthostatic Hypotension: **1.** Approve if the individual has tried two of the following, if two are formulary (or one if one is formulary): midodrine tablets (generics); fludrocortisone tablets; desmopressin tablets/nasal spray; dihydroergotamine injection/nasal spray; indomethacin capsules/injection; or pyridostigmine tablets. If none are formulary, approve.
Novacort gel PID: 56534	hydrocortisone 2%/ pramoxine 1%/ aloe 1% gel	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Epifoam, hydrocortisone-pramoxine cream, Pramosone cream, Pramosone lotion, or Pramosone ointment. If none are formulary, approve.
Novolin 70/30 Flexpen and Relion Novolin 70/30 Flexpen PID: 13364	insulin, 70/30 pen	**1.** Approve if the individual has tried Humulin 70/30 Kwikpens or Humulin 70/30 vials, if formulary. If both Humulin 70/30 Kwikpens and Humulin 70/30 vials are non-formulary, approve. **2.** If only Humulin 70/30 vials are formulary, approve in individuals who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.
Novolin 70/30 vials and Relion Novolin 70/30 vials PID: 13364	insulin, 70/30 vials	**1.** Approve if the individual has tried Humulin 70/30 vials or Humulin 70/30 Kwikpens, if formulary. If both Humulin 70/30 vials and Humulin 70/30 Kwikpens are non-formulary, approve.
Novolin N Flexpen and Relion Novolin N Flexpen PID: 13364	insulin, NPH pen	**1.** Approve if the individual has tried Humulin N Kwikpens or Humulin N vials, if formulary. If both Humulin N Kwikpens and Humulin N vials are non-formulary, approve. **2.** If only Humulin N vials are formulary, approve in individuals who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Novolin N vials and Relion Novolin N vials PID: 13364	insulin, NPH vials	**1.** Approve if the individual has tried Humulin N vials or Humulin N Kwikpens, if formulary. If both Humulin N vials and Humulin N Kwikpens are non-formulary, approve.
Novolin R Flexpen and Relion Novolin R U-100 Flexpen PID: 13364	insulin, regular pen	**1.** Approve if the individual has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve. **2.** Approve in individuals who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disable), or have coordination issues.
Novolin R U-100 vials and Relion Novolin R vials PID: 13364	insulin, regular vials	**1.** Approve if the individual has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.
NovoLog 70/30 and authorized generic (insulin aspart protamine-insulin aspart) and Relion Novolog 70/30 PID: 13734	insulin aspart protamine/insulin aspart, Flexpen (prefilled syringe)/vial	**1.** Approve if the individual has tried Humalog 75/25, if formulary. If Humalog 75/25 is non-formulary, approve.
NovoLog and authorized generic (insulin aspart) and Relion Novolog PID: 13365	insulin aspart syringe, cartridge/Flexpen (prefilled syringe)/vial	Approve if the individual meets (1 or 2): **1.** Approve if the individual meets the following (A, B, and C): A. Individual has tried Apidra, if formulary; AND B. Individual has tried Fiasp, if formulary; AND C. Individual has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Admelog; OR Note: A previous trial of Lyumjev would satisfy this requirement. **2.** Individual is using an insulin pump that is not compatible with the formulary alternative(s), approve. Note: If no products in A, B, or C are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).
Nucynta PID: 13295	tapentadol immediate-release tablets	**1.** Approve if the individual has tried three other oral immediate-release (NOT long-acting) centrally acting/opioid analgesics. Examples of oral immediate-release (NOT long-acting) centrally acting/opioid analgesics include, but are not limited to: hydromorphone (Dilaudid, generics), oxycodone hydrochloride tablets (Roxicodone, generics), oxymorphone (generics), morphine (generics), hydrocodone/acetaminophen (Vicodin, Vicodin ES,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Norco, Lortab, Lorcet, multiple generics), oxycodone/acetaminophen (Percocet, Endocet, Roxicet, multiple generics), tramadol (Ultram, generics), tramadol/acetaminophen (Ultracet, generics), **NOTE:** A trial of the requested product does not count toward this requirement.
Nucynta ER PID: 13582	tapentadol extended-release tablets	**1.** Approve if the individual has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], OxyContin, oxycodone ER tablets [generics], Xtampza ER, hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release tablets, or hydrocodone ER (Zohydro ER, Hysingla ER, generics). **2.** Individual is intolerant or allergic to morphine: approve if the individual has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve. **3.** Individual has renal insufficiency: approve if the individual has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve.
Nutropin AQ Nuspin PID: 24536	somatropin injection	<u>Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome:</u> **1.** Approve if the individual has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Omnitrope, Saizen, or Zomacton. If none are formulary, approve.
Nyvepria PID: 90834	pegfilgrastim-apgf	**1.** Approve if the individual meets BOTH of the following (a and b): a. The individual has tried four of the following, if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, or Ziextenzo; AND <u>Note:</u> If none are formulary, approve. b. Individual cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Individuals who have initiated therapy with Nyvepria and requires further medication to complete the current cycle of chemotherapy: approve.
Obredon PID: 52322	hydrocodone/ guaifenesin oral solution	**1.** Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine/guaifenesin oral solution (generics), Guaifenesin AC syrup, guaifenesin with codeine syrup (generics), Mar-Cof CG liquid, M-Clear WC liquid, Ninjacof XG liquid, Virtussin AC liquid. If none are formulary, approve if the individual has tried two other prescription or over-the-counter (OTC) cough and cold products.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Olumiant PID: 63804	baricitinib tablets	**1.** See Inflammatory Conditions - Olumiant PSM Policy criteria
Omnaris PID: 13780	ciclesonide nasal spray	**2.** Approve if the individual has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, Beconase AQ, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Zetonna. **Note:** Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Omnitrope PID: 24536	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: **1.** Approve if the individual has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Saizen, or Zomacton. If none are formulary, approve.
Ongentys PID: 87022	opicapone capsules	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with entacapone tablets (Comtan, generics). If entacapone tablets (Comtan, generics) are non-formulary, approve. **2.** If the individual has been on Ongentys for more than one month, approve.
Onglyza PID: 13645	saxagliptin tablets	**1.** Approve if the individual has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve.
Onureg PID: 87738	azacitadine tablets	Acute Myeloid Leukemia: Approve if the individual meets the following (1, 2, OR 3): 1. Individual is ≥ 18 years of age who achieved remission with intensive induction therapy, but cannot continue with conventional consolidation therapy; OR 2. Individual is ≥ 18 years of age with intermediate- or poor/adverse risk disease as maintenance therapy; OR Note: Examples of intermediate- and poor/adverse-risk cytogenetics/disease include the following genetic alterations: wild-type NPM1 without FLT3-ITD or with FLT3-ITDlow, MLLT3-KMT2A, DEK-NUP214, and KMT2A rearranged. 3. The individual has been started on therapy with Onureg.
Onzetra Xsail PID: 55505	sumatriptan nasal powder	**1.** Approve if the individual meets both of the following (a and b): a. Individual has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics) or Tosymra, if formulary; AND b. Individual has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary. Note: If no products from a. or b. are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Oracea PID: 13063 **Effective 7/1/2022**	doxycycline capsules 40 mg	Rosacea. **1.** Approve if the individual meets both of the following (A and B): A. Individual has tried two of the following: 1) a topical metronidazole-containing product, 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Individual has tried one other generic, oral doxycycline product.
Orencia for SC use PID: 53816	abatacept injection for subcutaneous use	**1.** See Inflammatory Conditions - Orencia PSM Policy criteria
Orencia IV PID: 53815	abatacept injection for intravenous use	**1.** **Individual has tried at least one biologic:** Approve. Examples: a tocilizumab product (e.g., Actemra intravenous or subcutaneous), a sarilumab product (Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars), a secukinumab product (e.g., Cosentyx), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya), or a ustekizumab product (e.g., Stelara SC). If none are formulary, approve. **2.** **According to the prescriber, the individual previously experienced a serious infection:** Approve. **3.** **Individual is currently taking Orencia intravenous or subcutaneous:** Approve if the individual has been established on Orencia intravenous or subcutaneous for ≥ 90 days. **4.** **Individual has been started on Orencia intravenous or subcutaneous for < 90 days**: Refer to the appropriate criteria above.
OsmoPrep PID: 82078	sodium phosphate, monobasic, monohydrate, sodium phosphate, dibasic anhydrous tablet	**1.** Approve if the individual meets one of the following criteria (a, b, c, or d): a. Individual has tried PEG3350 powder packet (Moviprep, generics). If PEG3350 powder packet (Moviprep, generics) are non-formulary, approve; OR b. If PEG3350 powder packet (generic of Moviprep) is unavailable; OR c. Individuals with phenylketonuria; OR d. Individuals with glucose-6-phosphate dehydrogenase deficiency. Approval duration: 1 month
Osphena PID: 27733	ospemifene tablets	**1.** Approve if the individual has tried one vaginal estrogen product from the following list (if one is formulary): estradiol cream (Estrace cream, generics), Femring vaginal ring, Premarin vaginal cream, Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), or Imvexxy If none are formulary, approve.
Otrexup PID: 40254	methotrexate injection for subcutaneous use; 10mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg	**1.** Approve if the individual has tried Rasuvo or RediTrex, if formulary. If neither are formulary, approve if, according to the prescriber, the individual and caregiver are unable to administer methotrexate injection (NOT including Otrexup, Rasuvo, or RediTrex).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Oxbryta PID: 78882	voxelotor tablets	Sickle Cell Disease in Individuals ≥ 4 Years of Age: **1.** Approve if the individual has tried or is currently receiving one of the following agents (if one is formulary): 1) a hydroxyurea product (hydroxyurea, Droxia, Siklos) OR 2) Endari. If none are formulary, approve. **2.** Individuals < 5 years of age: Approve if the individual has tried or is currently receiving one hydroxyurea product: hydroxyurea, Droxia, or Siklos, if one is formulary. If none are formulary, approve. **3.** If, according to the prescriber, the individual is not a candidate for a hydroxyurea product (e.g., an individual who is planning to become pregnant; a pregnant individual; or an individual with an immunosuppressive condition [such as cancer]), approve. **4.** Approve if the individual is currently receiving Oxbryta. <u>Note:</u> If the individual has already tried (or is currently taking) a hydroxyurea product, they would not be expected to try another hydroxyurea agent. For example, if the individual has already tried Droxia, the individual would not be required to try Siklos (even if Siklos is the only formulary agent).
oxycodone ER PID: 48517	oxycodone extended-release tablets	**1.** Approve if the individual has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. **2.** Individual is intolerant or allergic to morphine: approve if the individual has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **3.** Individual has renal insufficiency: approve if the individual has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **4.** Individuals ≥ 11 years and < 18 years of age: approve if the individual has tried OxyContin, if formulary. If Oxycontin is non-formulary, approve.
Ozobax and authorized generic PID: 77875	baclofen oral solution	**1.** Direct to oral baclofen tablets. **2.** Individual is unable to or has difficulty swallowing tablets, approve if the individual has tried Fleqsuvy suspension. If Fleqsuvy suspension is non-formulary, approve.
Palforzia PID: 80166	peanut [Arachis hypogaea] allergen powder-dnfp for oral administration	**1.** Approve Palforzia if the individual meets the following criteria (A, B, C, D, E, F, and G): **A.** The individual has a peanut allergy; AND **B.** The individual meets ONE of the following (i or ii): i. Individual is 4 to 17 years of age; OR ii. Individual is ≥ 18 years of age AND has been previously started on therapy with Palforzia prior to becoming 18 years of age; AND **C.** The medication is prescribed by or in consultation with an allergist or immunologist; AND **D.** Per the prescriber, the individual has a history of an allergic reaction to peanut that met each of the following (i, ii, and iii):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		i. The individual demonstrated signs and symptoms of a significant systemic allergic reaction; AND **Note:** Signs and symptoms of a significant systemic allergic reaction include hives, swelling, wheezing, hypotension, and gastrointestinal symptoms. ii. This reaction occurred within a short period of time following a known ingestion of peanut or peanut-containing food; AND iii. The prescriber deemed this reaction significant enough to require a prescription for an epinephrine auto-injector; AND **Note:** Examples of epinephrine auto-injectors include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors. **E.** The individual has a positive skin prick test (SPT) response to peanut with a wheal diameter ≥ 3 mm larger than the negative control; AND **F.** The individual has a positive in vitro test (i.e., a blood test) for peanut-specific IgE (psIgE) with a level ≥ 0.35 kUA/L; AND **G.** Per the prescriber, Palforzia will be used in conjunction with a peanut-avoidant diet.
Pazeo PID: 62937	olopatadine 0.7% ophthalmic solution	**1.** Approve if the individual has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.
Pennsaid PID: 13754	diclofenac sodium topical solution 2.0% pump	**1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products from the following list (if two are formulary, or one if one is formulary): prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics) or diclofenac sodium 1.5% topical solution (generics). If none are formulary, approve if the individual has tried over-the-counter Voltaren 1% gel.
Pertzye PID: 14767	pancrelipase delayed-release capsules	**1.** Approve if the individual has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Zenpep. If none are formulary, approve.
Pexeva PID: 13681	paroxetine mesylate tablets	**1.** Approve if the individual has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with four formulary SSRIs from the following list (if four are formulary or three if three are formulary or two if two are formulary, or one if one is formulary): citalopram (Celexa, generics), fluvoxamine (generics) escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), sertraline (Zoloft, generics), paroxetine HCl (Paxil, Paxil CR, generics), Viibryd, or Trintellix. If none are formulary, approve. **2.** Individual is currently taking or has taken Pexeva at any time in the past: approve. **3.** Suicidal ideation: approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Phexxi PID: 85985	L-lactic acid, citric acid, and potassium bitartrate vaginal gel	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Pifeltro PID: 63933	doravirine tablets	**1.** Approve if the individual has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Individuals already started on therapy with Pifeltro, approve.
Piqray PID: 69614	alpelisib tablets	**1.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the individual has a known PIK3CA mutation, Piqray is used in combination with fulvestrant, and the individual has tried one of the following agents: a Cyclin-Dependent Kinase 4/6 Inhibitor (e.g., Ibrance [palbociclib], Kisqali [ribociclib], Kisqali Co-Pack [ribociclib, letrozole], Verzenio [abemaciclib]), an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane), tamoxifen, or toremifene. **2.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the individual has a known PIK3CA mutation and the individual has already been started on Piqray.
Plenvu PID: 91756	polyethylene glycol; electrolytes; ascorbic acid powder for solution	**1.** Approve if the individual meets one of the following criteria (a, b, or c): a. Individual has tried PEG3350 powder packet (Moviprep, generics). If PEG3350 powder packet (Moviprep, generics) are non-formulary, approve; OR b. If PEG3350 powder packet (generic of Moviprep) is unavailable; OR c. Individuals with phenylketonuria. Approval duration: 1 month
Pliaglis and lidocaine 7% and tetracaine 7% cream (brand) PID: 52321	lidocaine 7% and tetracaine 7% cream	**1.** Approve if the individual has tried and cannot use two of the following, if two are formulary (or one if only one is formulary): lidocaine and prilocaine cream (generics), lidocaine cream (generics, multiple strengths), Livixil Pak, Relador Pak, Relador Pak Plus, DermacinRx Prizopak, Lidopril. If none are formulary, approve.
Pradaxa PID: 13473	dabigatran etexilate mesylate capsules	**1.** Approve if the individual has tried one of Eliquis, Savaysa, or Xarelto, if one is formulary **[documentation required].** If none are formulary, approve Pradaxa. **2.** Individual is less than (<) 18 years of age: approve if the individual has tried Xarelto [documentation required], if formulary. If Xarelto is non-formulary, approve. **3.** Individuals currently receiving Pradaxa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]): approve. **4.** Individuals currently receiving Pradaxa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip or knee replacement surgery): approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Praluent PID: 51801	alirocumab injection for subcutaneous use	**1.** Approve if the individual meets the following criteria (A and B): A. Individual meets the *Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Praluent Prior Authorization Policy* criteria; AND B. Individual meets both of the following (i and ii): i. Individual has tried Repatha (evolocumab subcutaneous injection); AND ii. Individual has experienced inadequate efficacy or significant intolerance, according to the prescriber. **2.** If the individual has met the standard *Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Praluent Prior Authorization Policy* criteria, but has not met exception criteria 1B, offer to review for the Preferred Product using the standard *Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Repatha Prior Authorization Policy* criteria.
Pred Mild PID: 62931	prednisolone acetate 0.12% ophthalmic suspension	**1.** Approve if individual has tried two formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, Inveltys, difluprednate (Durezol, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Approve if the individual has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the individual has tried one of the following, if one is formulary: loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, or difluprednate (Durezol, generics). If none are formulary, approve.
Pregenna PID: 87745	beta carotene, ascorbic acid, cholecalciferol, .alpha.-tocopherol acetate, pyridoxine hydrochloride, biotin, folic acid, levomefolate calcium, cyanocobalamin, calcium carbonate, magnesium oxide, ferrous bisglycinate, and potassium iodide tablet	**1.** Direct the individual to generic prenatal vitamins.
Pregnyl PID: 62846	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the individual has tried one product from the following list (if one is formulary): chorionic gonadotropin, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the individual has tried chorionic gonadotropin or Novarel, if formulary. If neither are formulary, approve. **3.** Individuals with a latex allergy: approve if the individual has tried Novarel, if formulary. If Novarel is non-formulary, approve. **4.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the individual may be at risk of missing the optimal administration

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).
Premarin PID: 91407	conjugated estrogens tablets	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: estradiol tablets (Estrace, generics), Menest tablets, Enjuvia tablets, or Cenestin tablets. If none are formulary, approve.
Premphase PID: 91408	conjugated estrogens//medroxy progesterone tablets	**1.** Approve if the individual meets the following (A, B, and C): **A.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND **B.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND **C.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Prempro PID: 91409	conjugated estrogens/ medroxyprogesteron e tablets	**1.** Approve if the individual meets the following (A, B, and C): **A.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND **B.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND **C.** Individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Prezcobix PID: 50876	darunavir and cobicistat tablets	**1.** Approve if the individual has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, Reyataz, Crixivan, Viracept, Norvir, Invirase, Lexiva, Prezista, Evotaz, Kaletra). **2.** If the individual, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. **3.** Approve if the individual has been started on Prezcobix.
Prilosec oral suspension PID: 13416	omeprazole delayed-release oral suspension	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Individuals < 18 years of age OR individuals who have difficulty swallowing tablets/capsules: Approve if the individual has tried two proton pump inhibitors (PPIs). **3.** Individuals < 1 year of age: approve if the individual has tried Nexium DR packet (granules for oral suspension), if formulary. If Nexium DR packet (granules for oral suspension), is non-formulary, approve. **Note:** The requested agent would NOT count as a trial of an alternative.
Primlev tablet PID: 82079	oxycodone-acetaminophen	**1.** Direct individual to use oxycodone-acetaminophen.
ProAir Digihaler PID: 76593	albuterol sulfate inhalation powder	**1.** Approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), ProAir Respiclick, albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generics to Ventolin HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Individuals who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried ProAir Respiclick, if formulary. If ProAir Respiclick is non-formulary, approve.
ProAir Respiclick PID: 51360	albuterol sulfate inhalation powder	**1.** Approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), ProAir Digihaler, albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generics to Ventolin HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Individuals who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the individual has tried ProAir Digihaler, if formulary. If ProAir Digihaler is non-formulary, approve.
Proctofoam-HC PID: 87743	pramoxine hydrochloride hydrocortisone acetate aerosol, foam	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with pramoxine-hydrocortisone cream.
Procysbi PID: 30954, 49786	cysteamine bitartrate delayed-release capsules and granule packets	**1.** Approve if the individual meets the following criteria (A, B, C, and D): A. Individuals with nephropathic cystinosis; AND B. According to the prescriber, the diagnosis was confirmed by one of the following (i or ii): i. Genetic testing confirmed a mutation of the CTNS gene; OR ii. White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory; AND C. The individual will not be using Cystagon and Procysbi concurrently; AND D. The individual has tried Cystagon, if formulary. If Cystagon is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Prolate solution PID: 95110	oxycodone and acetaminophen oral solution	**1.** Approve if the individual has tried and cannot take oxycodone-acetaminophen tablets. **2.** Approve if the individual is unable to swallow or has difficulty swallowing tablets.
Prolia PID: 13598	denosumab injection for subcutaneous use	**1.** Approve if individual has tried one of the following products: an oral or intravenous bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, zoledronic acid [Reclast, generics], ibandronate injection [Boniva, generics]), a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Individuals with severe renal impairment (e.g., creatinine clearance < 35 mL/min) or chronic kidney disease (CKD): approve. **3.** Individuals who have had an osteoporotic fracture or a fragility fracture: approve. **4.** Individuals who cannot swallow/have difficulty tablets, cannot remain in an upright position (post oral bisphosphonate administration), or have a history of a gastrointestinal medical condition (e.g., esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]): approve. **5.** Treatment of bone loss (to increase bone mass) in individuals at high risk for fracture receiving androgen deprivation therapy (e.g., Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension] or has undergone bilateral orchiectomy) for nonmetastatic prostate cancer: approve. **6.** Treatment of bone loss (to increase bone mass) in individuals at high risk for fracture receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole [Arimidex, generics], letrozole [Femara, generics], and exemestane [Aromasin, generics]) for breast cancer: approve.
Pulmicort Flexhaler PID: 13258	budesonide inhalation powder	**1.** Approve if the individual has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. a. If the individual is < 12 years of age, approve if the individual has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. i. If the individual is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the individual has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus), or Qvar RediHaler. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. If the individual is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the individual has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus), or Qvar RediHaler. If none are formulary, approve.
Pylera PID: 13794	bismuth subcitrate potassium, metronidazole plus tetracycline capsules	**1.** Approve if the individual meets ONE of the following (A or B): A. The individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth subcitrate + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]); OR B. The individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Omeclamox-Pak, Helidac, or Talicia). Approval duration: 1 month
Qbrelis PID: 56270, 67095	lisinopril oral solution	**1.** Approve if the individuals has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve. **2.** Approve if the individual cannot swallow or has difficulty swallowing tablets.
Qbrexza PID: 63797 **Effective 7/1/2022**	glycopyrronium cloth 2.4%, for topical use	Hyperhidrosis, Primary Axillary in an individual ≥ 9 years of age. Note: Qbrexza is not intended for application to areas other than the axillae. Approve if the individual has tried Drysol, Hypercare, Xerac AC, Certain Dri or generic, or Bromi-lotion.
Qdolo PID: 90591	tramadol hydrochloride oral solution	**1.** Direct the individual to tramadol tablets. **2.** Approve if the individual is unable to swallow or has difficulty swallowing tramadol tablets.
Qelbree PID: 94250	viloxazine extended-release capsules	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with atomoxetine (Strattera, generics), if formulary. If atomoxetine (Strattera, generics) is non-formulary, approve. **2.** If the individual is unable to swallow or has difficulty swallowing tablets, approve.
Qinlock PID: 83718	ripretinib tablets	Gastrointestinal stromal tumor: **1.** Approve if the individual has been previously treated with at least two other kinase inhibitors. Note: Examples of kinase inhibitors are imatinib (Gleevec), Sutent, Stivarga, Nexavar, Votrient, Tasigna, Sprycel, Ayvakit. **2.** Approve if the individual has already been started on therapy with Qinlock.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Qnasl PID: 13711	beclomethasone dipropionate nasal aersol	**1.** Approve if the individual has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, Beconase AQ, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Zetonna. **Note:** Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Qtern PID: 87744	dapagliflozin/ saxagliptin tablets	**1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Glyxambi and Steglujan, if formulary. If one if formulary, try one, if neither are formulary, approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary). SGLT-2 inhibitors: Farxiga, Invokana, Jardiance, Steglatro. DPP-4 inhibitors: Januvia, Nesina, Onglyza, Tradjenta. **Note**: If the individual has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product. A trial of the request agent would NOT count toward this requirement.
Recorlev PID: 102054	levoketoconazole tablets	Endogenous Cushing's Syndrome in an individual ≥ 18 years of age. **1.** Approve if the individual meets the following (A and B): A. Individual has tried ketoconazole; AND B. Individual has tried two of Isturisa, Metopirone (metyrapone), or Lysodren. If neither Isturisa nor Metopirone are formulary, approve if the individual has tried ketoconazole. If both or one of Isturisa or Metopirone (metyrapone) are formulary, then one of those agents AND ketoconazole would need to be tried. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. **2.** Approve if the individual has already been started on Recorlev.
Rayos PID: 49782	prednisone delayed-release tablets	**1.** Approve if the individual has tried prednisone immediate-release tablets AND had inadequate efficacy with the product, according to the prescriber, OR experienced adverse events severe enough to warrant discontinuation of the product.
RediTrex PID: 93883	methotrexate injection for subcutaneous use; 7.5 mg, 10 mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg	**1.** Approve if the individual has tried Otrexup or Rasuvo, if formulary. If neither are formulary, approve if, according to the prescriber, the individual and caregiver are unable to administer methotrexate injection (NOT including RediTrex, Otrexup, or Rasuvo).
Relafen DS PID: 76148	nabumetone 1,000 mg tablets	**1.** Approve if the individual has tried five prescription-strength NSAIDs. **Note:** For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Reltone PID: 93685	ursodiol capsules 200 mg, 400 mg	**1.** Approve if the individual has tried generic ursodiol capsules or tablets. **2.** Approve, if according to the prescriber, the individual is unable to achieve the appropriate dosage requirement with ursodiol capsules.
Rhopressa PID: 94616	netarsudil ophthalmic solution 0.02%	**1.** Approve if the individual meets the following criteria (A, B, and C): A. Individual has tried one ophthalmic prostaglandin product; AND Note: Examples of ophthalmic prostaglandin products include: latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, Vyzulta, Xelpros, or Zioptan. B. Individual has tried one ophthalmic beta-blocker product; AND Note: Examples of ophthalmic beta-blockers products include: levobunolol solution, timolol maleate solution (Istalol, generics), betaxolol ophthalmic solution, Betopic S, carteolol opthalmic solution, timolol (Timoptic, generics), Timoptic in Ocudose, timolol gel-forming solution (Timoptic XE, generics). C. Individual has tried either one ophthalmic alpha-adrenergic agonists or an ophthalmic carbonic anhydrase inhibitor. Note: Examples of ophthalmic alpha-adrenergic agonists include: Alphagan P, brimonidine solution (Alphagan, generics), apraclonidine solution. Note: Examples of ophthalmic carbonic anhydrase inhibitors include: Azopt, dorzolamide (Trusopt, generics). Note: A combination ophthalmic agent containing the requested drug products, would count as a trial of the respective alternatives.
Rocklatan PID: 94617	netarsudil/latanoprost ophthalmic solution	**1.** Approve if the individual has tried latanoprost ophthalmic solution (Xalatan, generics) AND Rhopressa, if Rhopressa is formulary. **2.** If Rhopressa is non-formulary, approve if the individual meets the following criteria (A, B, and C): A. Individual has tried one ophthalmic prostaglandin product; AND Note: Examples of ophthalmic prostaglandin products include: latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, Vyzulta, Xelpros, or Zioptan. B. Individual has tried one ophthalmic beta-blocker product; AND Note: Examples of ophthalmic beta-blockers products include: levobunolol solution, timolol maleate solution (Istalol, generics),

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		betaxolol ophthalmic solution, Betopic S, carteolol opthalmic solution, timolol (Timoptic, generics), Timoptic in Ocudose, timolol gel-forming solution (Timoptic XE, generics). C. Individual has tried either one ophthalmic alpha-adrenergic agonists or an ophthalmic carbonic anhydrase inhibitor. Note: Examples of ophthalmic alpha-adrenergic agonists include: Alphagan P, brimonidine solution (Alphagan, generics), apraclonidine solution. Note: Examples of ophthalmic carbonic anhydrase inhibitors include: Azopt, dorzolamide (Trusopt, generics). Note: A combination ophthalmic agent containing the requested drug products, would count as a trial of the respective alternatives.
Roszet and authorized generic [Authorized generic only] PID: 94575	rosuvastatin and ezetimibe	**1.** Approve if the individual meets the following criteria (A and B): A. Individual has tried ezetimibe; AND B. Individual has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with atorvastatin (Lipitor, generics) or rosuvastatin (Crestor, generics). If neither of atorvastatin (Lipitor, generics) nor rosuvastatin (Crestor, generics) are formulary, approve.
Rukobia PID: 85182	fostemsavir extended-release tablets	See standard Human Immunodeficiency Virus - Rukobia Prior Authorization Policy criteria.
Saizen/Saizen Prep PID: 24536	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: **1.** Approve if the individual has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Zomacton. If none are formulary, approve.
Savaysa PID: 50066	edoxaban tablets	**1.** Approve if the individual has tried one of the following, if one is formulary: Pradaxa, Xarelto, or Eliquis **[documentation required]**. If none are formulary, approve. **2.** Individuals currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]): approve. **3.** Individuals using Savaysa for treatment of DVT or PE associated with cancer: approve if the individual has tried Eliquis **[documentation required]**, if formulary. If Eliquis is non-formulary, approve. **4.** Individuals currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery): approve.
Scemblix PID: 99714	asciminib tablets	Chronic Myeloid Leukemia (Philadelphia chromosome-positive). **1.** Approve if the individual is T315I-positive. **2.** Approve if the individual has tried two other tyrosine kinase inhibitors. **3.** Examples of other tyrosine kinase inhibitors include: imatinib tablets (Gleevec, generics), Sprycel, Tasigna, Bosulif, Iclusig.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		4. Approve if the individual has been started on Scemblix.
Seglentis PID: 102243	celecoxib and tramadol hydrochloride tablets	**1.** Direct the individual to tramadol tablets and celecoxib capsules as separate agents.
Semglee (non YFGN) PID: 98955	insulin glargine U-100 vial and pen	**1.** Individual is directed to use Semglee (YFGN) [brand] or Insulin glargine-YFGN, if formulary. If neither are formulary, approve if the individual has tried one of Lantus or Basaglar, if formulary. If Lantus and Basaglar are non-formulary, approve.
Sernivo spray PID: 105810 **Effective 7/1/2022**	betamethasone dipropionate spray 0.05%	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide. NOTE: The five products must be chemically unique.
Siklos PID: 62582	hydroxyurea tablets	**1.** Approve is the individual has tried Droxia, if formulary. If Droxia is non-formulary, approve. **2.** If the individual requires Siklos 100 mg or 1,000 mg tablets to achieve a dosage that cannot be achieved with the available strengths of Droxia, approve. **3.** If the individual cannot swallow or has difficulty swallowing Droxia capsules, approve.
Siliq PID: 59159	brodalumab for subcutaneous injection	**1.** See Inflammatory Conditions - Siliq PSM Policy criteria
Simponi SC PID: 13289	golimumab subcutaneous injection	**1.** See Inflammatory Conditions - Simponi SC PSM Policy criteria
Sitavig PID: 44692, 49778	acyclovir buccal tablets	**1.** Approve if the individual has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), Denavir 1% cream, Xerese 5%/1% cream, acyclovir 5% cream (Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.
Skytrofa PID: 99258	lonapegsomatropin-tcgd subcutaneous injection	Growth hormone deficiency in individuals ≥ 1 year of age to < 18 years of age. **1.** Approve if the individual has tried, and according to the prescriber, has experienced inadequate efficacy (i.e., individual has tried for 12 months and has a growth rate of less than 2 cm per year) with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton. **2.** Approve if the individual meets BOTH of the following (A and B): A. Individual has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; AND

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		B. Individual cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: A trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the individual would NOT be required to try TWO products- only ONE.
Slynd PID: 91410	drospirenone tablet	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried one progesterone-only contraceptive containing norethindrone; OR Examples of progesterone-only contraceptives containing norethindrone include Ortho Micronor, Camila, Deblitane, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Norlyroc, Sharobel. **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Soaanz PID: 103615	torsemide tablets	**1.** Approve if the individual has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): torsemide tablets, bumetanide (Bumex, generics), furosemide (Lasix, generics). If none are formulary, approve.
sofosbuvir/velpatasvir (Authorized generic for Epclusa) 400 mg/100 mg tablets PID: 64671	sofosbuvir/velpatasvir tablets 400 mg/100 mg tablets	**1.** Individual is directed to use Epclusa. If Epclusa is non-formulary, approve. Approval duration: 24 weeks
Sorilux and authorized generic [Authorized generic only] PID: 49800	calcipotriene foam	**1.** Approve if the individual has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve. **2.** Approve if the individual has tried calcipotriene cream or ointment. **3.** If the individual is using the requested medication for plaque psoriasis and is between the ages ≥ 4 and < 18 years of age, approve.
Sovaldi PID: 49513	sofosbuvir tablets and oral pellets	**1.** See *Hepatitis C - Sovaldi Prior Authorization Policy* Approval duration: Varies
Spravato PID: 66004	esketamine nasal spray	**1.** For the diagnosis of Treatment-Resistant Depression: approve if the individual meets the following criteria (A, B, C, and D): A. The individual is ≥ 18 years of age; AND B. The individual meets both of the following (i and ii): i. The individual has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class, according to the prescriber; AND Note: Different pharmacologic classes of antidepressants inlcude selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, bupropion, mirtazapine, etc.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		ii. Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber; AND C. Individual is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. The medication is prescribed by a psychiatrist. **2.** Major Depressive Disorder with Acute Suicidal Ideation or Behavior: approve if the individual meets the following criteria (A, B, C, and D): A. The individual is ≥ 18 years of age; AND B. The individual has major depressive disorder that is considered to be severe, according to the prescriber; AND C. The individual is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. The medication is prescribed by a psychiatrist. **3.** For the diagnosis of Treatment-Resistant Depression OR Major Depressive Disorder with acute suicidal ideation or behavior: approve if the individual has already started therapy with Spravato.
Sprix and authorized generic [Authorized generic only] PID: 13533	ketorolac tromethamine nasal spray	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried. **2.** Approve for individuals with difficulty swallowing or for individuals who cannot swallow.
Stribild PID: 53334	elvitegravir/ cobicistat/ emtricitabine/ tenofovir tablets	**1.** Approve if the individual has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the individual has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Triumeq, Juluca, Isentress or Intress-HD). **3.** Individuals already started on therapy with Stribild: approve.
Striverdi Respimat PID: 47073	olodaterol inhalation spray	**1.** Approve if the individual has tried Serevent Diskus, if formulary. If Serevent Diskus is non-formulary, approve. **2.** Individuals who have a low inspiratory flow rate and are unable to use a dry-powder inhaler (DPI): approve.
Suprep PID: 91757	magnesium sulfate; potassium sulfate;	**1.** Approve if the individual has tried one other bowel evacuant product (e.g., peg-electrolyte solution, Colyte, GaviLyte, Golytely, Nulytely, TriLyte).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
	sodium sulfate solution	**2.** If, per the prescriber, the individual requires a low volume bowel preparation, approve if the individual meet one of the following criteria (a, b, c, d, or e): a. Individual has tried PEG3350 powder packet (Moviprep, generics). If PEG3350 powder packet (Moviprep, generics) are non-formulary, approve; OR b. If PEG3350 powder packet (generic of Moviprep) is unavailable; OR c. The individual is less than 18 years of age; OR d. Individuals with phenylketonuria; OR e. Individuals with glucose-6-phosphate dehydrogenase deficiency. Approval duration: 1 month
Sutab PID: 92684	sodium sulfate, magnesium sulfate, and potassium chloride tablets	**1.** Approve if the individual meet one of the following criteria (a, b, c, or d): a. Individual has tried PEG3350 powder packet (Moviprep, generics). If PEG3350 powder packet (Moviprep, generics) are non-formulary, approve; OR b. If PEG3350 powder packet (generic of Moviprep) is unavailable; OR c. Individuals with phenylketonuria; OR d. Individuals with glucose-6-phosphate dehydrogenase deficiency. Approval duration: 1 month
Taperdex PID: 59120	dexamethasone 1.5 mg tablets (6 day and 12 day dose packs)	**1.** The individual is directed to use the dexamethasone 1.5 mg tablets (not packed as dose packs). If dexamethasone 1.5 mg tablets (not packaged as dose packs) are non-formulary, approve. Approval duration: 14 days
Tavneos PID: 99207	avacopan capsules	Anti-Neutrophil Cytoplasmic Autoantibody (ANCA)-Associated Vasculitis. Approve if the individual meets the following (A, B, and C): A. Individual has granulomatosis with polyangiitis or microscopic polyangiitis; AND Note: Granulomatosis with polyangiitis is also known as Wegener's granulomatosis. B. Individual has active disease; AND Note: This includes individuals that have newly diagnosed or relapsed disease. This does not include individuals already in remission. C. Individual has tried or is currently taking at least one immunosuppressant. Note: Examples of immunosuppressants include rituximab, methotrexate, azathioprine, or mycophenolate mofetil.
Tazorac 0.05% cream PID: 62348 **Effective 7/1/2022**	tazarotene cream 0.05%	**1.** Approve if the individual has tried one of tazarotene 0.1% cream (Tazorac 0.1% cream, generics) or Tazorac gel, if one is formulary. If neither are formulary, approve.
Tazorac 0.05% gel PID: 62351	tazarotene gel 0.05%	**1.** Approve if the individual has tried one of tazarotene 0.1% cream (Tazorac 0.1% cream, generics), Tazorac 0.05% cream, or Tazorac 0.1% gel, if one is formulary. If none are formulary, approve.

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Tazorac 0.1% gel PID: 62351 **Effective 7/1/2022**	tazarotene gel 0.1%	Psoriasis. **1.** Approve if the individual has tried tazarotene 0.1% cream (Tazorac 0.1% cream, generics), if formulary. If tazarotene 0.1% cream (Tazorac 0.1% cream, generics) are non-formulary, approve. Other diagnoses, including acne vulgaris. **1.** Approve if the individual has tried one of tazarotene 0.1% cream (Tazorac 0.1% cream, generics), Tazorac 0.05% cream, or Tazorac 0.05% gel, if formulary. If none are formulary, approve if the individual has tried a topical tretinoin-containing product. Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics).
Tecfidera PID: 99540	dimethyl fumarate delayed-release capsules	See standard Preferred Specialty Management policy criteria.
Tepmetko PID: 92823	tepotinib tablets	Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification: **1.** Approve if the individual has tried Tabrecta. If Tabrecta is non-formulary, approve. **2.** Approve if the individual has already been started on Tepmetko.
Testred PID: 49788	methyltestosterone 10 mg capsules	**1.** Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): methyltestosterone capsules (generics), Android, or Methitest. If none are formulary, approve.
Tezspire PID: 101359	tezepelumab-ekko subcutaneous injection	Asthma. Approve if the individual meets (A or B): A. Initial therapy in an individual ≥ 12 years of age: **1.** Approve if the individual has tried one of the following: Dupixent, Xolair, Nucala, Cinqair, or Fasenra. If none are formulary, approve. a. Individuals < 18 years of age: Approve if the individual has tried one of the following: Dupixent, Xolair, Nucala, or Fasenra. If none are formulary, approve. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. **2.** Approve if per the prescriber, based on the asthma phenotype, the individual is not a candidate for one of the following therapies: Dupixent, Xolair, Nucala, Cinqair, or Fasenra. B. Individual Continuing Therapy with Tezspire: Approve.
Thalitone 15 mg PID: 98708	chlorthalidone 15 mg tablets	**1.** Direct the individual to chlorthalidone tablets. Available as 25 mg, 50 mg. **2.** Approve if the individual's prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Thyquidity PID: 92407	levothyroxine sodium oral solution	**1.** Approve if the individual has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules. If none are formulary, approve. **2.** If the individual cannot swallow or has difficulty swallowing, approve if the individual has tried Tirosint oral solution, if formulary. If Tirosint oral solution is non-formulary, approve.
Timoptic in Ocudose PID: 13672	timolol maleate 0.25% and 0.5% ophthalmic solution	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list: timolol ophthalmic solution (Timoptic, generics), levobunolol ophthalmic solution (Betagan, generics), timolol once-daily (Istalol, generics), timolol gel-forming solution (Timoptic XE, generics), betaxolol ophthalmic solution (generics), Betoptic S, carteolol opthalmic solution (generics), if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** Approve if the individual has a known sensitivity to a preservative or when use of a preservative-free topical medication is advisable.
Tirosint PID: 65990	levothyroxine oral solution	**1.** Approve if the individual has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules. If none are formulary, approve. **2.** If the individual cannot swallow or has difficulty swallowing, approve if the individual has tried Thyquidity oral solution, if formulary. If Thyquidity is non-formulary, approve.
Tirosint and authorized generic PID: 13055	levothyroxine capsules	**1.** Approve if the individual has tried five formulary levothyroxine products from the following list (if five are formulary or four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint oral solution. If none are formulary, approve.
Tivorbex and authorized generic PID: 51576	indomethacin, submicronized capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** Examples include: indomethacin (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
TobraDex ST PID: 94576	tobramycin 0.3%/dexamethasone 0.05% ophthalmic suspension	**1.** Approve if the individual has tried tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics), if formulary. If tobramycin-dexamthasone ophthalmic suspension (Tobradex, generics) are non-formulary, approve. **2.** For the treatment of currently active eye infections: approve in individuals already receiving TobraDex ST to complete the course of therapy.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Tolsura PID: 65657	itraconazole capsules	**1.** Approve if the individual has tried one of itraconazole capsules (Sporanox, generics) or itraconazole oral solution (Sporanox liquid, generics). **NOTE:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product. **2.** Individual has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **3.** Deny: If the individual is requesting Tolsura for a diagnosis of onychomycosis. **NOTE:** If the individual is requesting Tolsura for a diagnosis of onychomycosis, the request should be denied regardless of what the individual has tried for the current condition or if the individual has already been started on the product.
Tradjenta PID: 13647	linagliptin tablets	**1.** Approve if the individual has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, generics), Onglyza, or Januvia. If none are formulary, approve. **2.** Individuals with a history of heart failure or a history of renal impairment: Approve if the individual has tried Januvia, if formulary. If Januvia is non-formulary, approve.
Treximet PID: 13453	sumatriptan/ naproxen sodium tablets	Approve if the individual has tried naproxen AND sumatriptan tablets (Imitrex, generics), if formulary. If sumatriptan tablets (Imitrex, generics) are non-formulary, approve. **NOTE:** A trial of the requested agent would NOT count toward meeting this requirement.
Tri-luma cream PID: 97531	fluocinolone acetonide 0.01%/hydroquinone 4%/tretinoin 0.05% cream	Direct the individual to the separate entities: fluocinolone 0.01% cream- hydroquinone 4% cream- tretinoin 0.05% cream.
Trinaz PID: 87745	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin, pyridoxal phosphate anhydrous, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, and potassium iodide tablet, film coated	**1.** Direct the individual to generic prenatal vitamins.
Truseltiq PID: 95080	nfigratinib capsules	Cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. **1.** Approve if the individual has tried Pemazyre. If Pemazyre is non-formulary, approve. **2.** Approve if the individual has already been started on therapy with Truseltiq.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Tudorza Pressair PID: 15262	aclidinium bromide inhalation powder	**1.** Approve if the individual has tried one product from the following list (if one is formulary): Incruse Ellipta, Spiriva HandiHaler, or Spiriva Respimat. If none are formulary, approve.
Tussicaps PID: 52326	hydrocodone/ chlorpheniramine capsules	1. Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine and promethazine syrup (Promethazine VC codeine syrup, generics), hydrocodone polistirex/chlorpheniramine polystirex pennkinetic suspension (Tussionex pennkinetic suspension, generics), Tuzistra XR oral suspension, Z-Tuss AC liquid. If none are formulary, approve if the individual has tried two other prescription or over-the-counter (OTC) cough and cold products.
Tuzistra XR PID: 52324	codeine/ chlorpheniramine extended-release oral suspension	1. Approve if the individual has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine and promethazine syrup (Promethazine VC codeine syrup, generics), hydrocodone polistirex/chlorpheniramine polystirex pennkinetic suspension (Tussionex pennkinetic suspension, generics), Z-Tuss AC liquid, Tussicaps. If none are formulary, approve if the individual has tried two other prescription or over-the-counter (OTC) cough and cold products.
Twirla PID: 85022	levonorgestrel and ethinyl estradiol transdermal system	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]); OR Note: A trial of five different oral contraceptive agents would meet the requirement. **2.** Approve if according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Tyblume PID: 94252	levonorgestrel 0.1 mg and ethinyl estradiol 0.02 mg tablets	Approve if the individual meets one of the following criteria (1 or 2): **1.** Individual has tried four other oral contraceptive agents; OR **2.** If according to the prescriber, these alternatives would not be as medically appropriate for the individual as the requested non-formulary drug.
Udenyca PID: 65442	pegfilgrastim-cbqv injection	**1.** Approve if the individual meets BOTH of the following (a and b): a. The individual has tried four of the following, if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Ziextenzo, or Nyvepria; AND Note: If none are formulary, approve. b. Individual cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Individuals who have initiated therapy with Udenyca and requires further medication to complete the current cycle of chemotherapy: approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Ultravate Lotion PID: 105809 **Effective 7/1/2022**	halobetasol propionate lotion 0.05%	**1.** Approve if the individual has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.
Upneeq PID: 86268	oxymetazoline hydrochloride 0.1% ophthalmic solution	**1.** No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Upneeq. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)
Valsartan oral solution (previously Prexxartan) PID: 106407	valsartan oral solution	**1.** Direct the individual to valsartan tablets. **2.** Approve if the individual is unable to or has difficulty swallowing oral tablets.
Vanatol LQ PID: 58422	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg per 15 mL oral solution	**3.** Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve. **4.** Approve if the individual cannot swallow or has difficulty swallowing.
Vanatol S PID: 60460	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg per 15 mL oral solution	**1.** Approve if the individual has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve. **2.** Approve if the individual cannot swallow or has difficulty swallowing.
Veltin PID: 13474	clindamycin phosphate and tretinoin gel	**1.** Approve if the individual has tried BOTH a clindamycin- AND a tretinoin-containing product (for example, Ziana, generic clindamycin/tretinoin, Retin-A, generic tretinoin, Cleocin-T, generic clindamycin).
Ventolin HFA PID: 65956	albuterol sulfate inhalation aerosol	**1.** Approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), ProAir Respiclick, ProAir Digihaler, albuterol HFA inhaler (authorized generic to Ventolin HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Individuals < 12 years of age or individuals who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the individual has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), albuterol HFA inhaler (authorized generic to Ventolin HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve.
Verdeso PID: 63056	desonide foam	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Examples of topical steroid products include: desonide, alclometasone dipropionate, betamethasone valerate, fluocinolone acetonide, triamcinolone, flurandrenolide, hydrocortisone butyrate. **Note**: The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).
Veregen PID: 13141 **Effective 7/1/2022**	sinecatechins ointment 15%	**1.** Approve if the individual has tried both 1) podofilox topical solution or Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If none are formulary, approve. **2.** For perianal warts, approve if the individual has tried both 1) Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If neither are formulary approve.
Vesicare LS PID: 92409	solifenacin succinate oral suspension	**1.** Approve if the individual has tried oxybutynin solution/syrup OR Myrbetriq Granules, if formulary. If neither are formulary, approve. **2.** Individual is < 5 years of age: approve if the individual has tried Myrbetriq Granules, if formulary. If Myrbetriq Granules are non-formulary, approve. **3.** Individuals < 3 years of age, approve. Note: If the individual has tried any oxybutynin-containing product (e.g., immediate-release or extended-release tablets), this would meet the requirement for a trial of an oxybutynin product. Note: If the individual has tried Mybetriq tablets, this would meet the requirement for a trial of Myrbetriq granules.
Victoza PID: 13675	liraglutide (rDNA origin) injection	**1.** Approve if the individual has tried three formulary alternatives from the following list (or two if two are formulary or one if only one is formulary): Adlyxin, Trulicity, an exenatide product (Byetta, Bydureon BCise), or Ozempic **[documentation required].** If none are formulary, approve. **NOTE:** Bydureon BCise and Byetta count as one alternative. **2.** If the individual is less than 18 years of age, approve if the individual has tried Bydureon BCise **[documentation required],** if formulary. If Bydureon BCise is non-formulary, approve. Note: If the individual has tried Bydureon or Byetta, this would satisfy the requirement. **3.** If the individual, according to the prescriber, has established cardiovascular disease OR at least two risk factors for cardiovascular disease, approve if the individual has tried both Ozempic and Trulicity **[documentation required],** if formulary (or one if one is formulary). If neither are formulary, approve. **4.** Individual with an estimated creatinine clearance (CrCl) < 60 mL/min: approve if the individual has tried both Trulicity and Ozempic **[documentation required],** if formulary (or one if one is formulary). If neither are formulary, approve.
Viibryd PID: 13678	vilazodone tablets	**1.** Approve if the individual has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with four formulary SSRIs from the following list (if four are formulary or three if three are formulary or two if two are formulary, or one if one is formulary): citalopram (Celexa, generics), fluvoxamine (generics), escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), sertraline (Zoloft,

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		generics), paroxetine HCl (Paxil, Paxil CR, generics), Pexeva, or Trintellix. If none are formulary, approve. **2.** Individual is currently taking or has taken Viibryd at any time in the past: approve. **3.** Suicidal ideation: approve.
Vivlodex PID: 53227	meloxicam capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDs. **Note:** Examples include: meloxicam (Mobic, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Vuity PID: 101659	pilocarpine 1.25% ophthalmic solution	**1.** No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)
Winlevi PID: 91205	clascoterone cream 1%	Acne Vulgaris in an individual ≥ 12 years of age. **1.** Approve if the individual meets the following (A and B): A. Individual has tried at least one prescription topical retinoid; AND <u>Note:</u> Examples of a prescription topical retinoid are adapalene, Aklief (trifarotene 0.005% cream), tazarotene (Tazorac 0.1% cream [generic], Tazorac 0.1% gel), and tretinoin. B. Individual has tried at least three other prescription topical acne therapies. <u>Note:</u> Examples of other prescription topical therapies for acne include: Aczone (dapsone 7.5% gel; dapsone 5% gel [generic]), Azelex (azelaic acid 20% cream), topical clindamycin, topical erythromycin, and topical minocycline (Amzeeq [minocycline 4% foam]).
Xadago PID: 59647	safinamide tablets	**1.** Approve if the individual has tried two products from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Azilect, generics), or Zelapar. If none are formulary, approve. **2.** Individuals already started on Xadago, approve.
Xatmep PID: 59569, 59803	methotrexate oral solution	**1.** Approve if the individual cannot swallow or has difficulty swallowing oral methotrexate tablets. **2.** Approve if the individual's dose cannot be obtained using whole methotrexate tablets.

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Xelpros PID: 64855	latanoprost 0.005% ophthalmic emulsion	**1.** Approve if the individual has tried latanoprost ophthalmic solution (Xalatan, generics), if formulary. If latanoprost ophthalmic solution (Xalatan, generics) are non-formulary, approve. **2.** 2. Individual has a benzalkonium chloride sensitivity: approve
Xerese PID: 13648 **Effective 7/1/2022**	acyclovir and hydrocortisone cream, 5%/1%	**1.** Approve if the individual has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), acyclovir 5% cream (Zovirax 5% cream, generics), Denavir 1% cream, Sitavig tablets, or over-the-counter (OTC) Abreva 10% cream.
Ximino and authorized generic PID: 81886	minocycline ER capsule	**1.** Approve if the individual has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve
Xolegel PID: 42153	ketoconazole 2% gel	**1.** Approve if the individual has tried four topical antifungals (e.g., naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra [over-the-counter {OTC}], clotrimazole 1% cream [OTC formulation], econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam [Extina, generics], Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel [generics], Luzu 1% cream, Mentax 1% cream).
Xopenex HFA PID: 31376	levalbuterol inhalation aerosol	**1.** Approve if the individual has tried one formulary albuterol containing inhaler from the following list: albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (ProAir HFA, generics), ProAir Respiclick, ProAir Digihaler, if one is formulary. If none are formulary, approve. **2.** Individuals < 12 years of age or individuals who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the individual has tried one product from the following list (if one is formulary): albuterol HFA (ProAir HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (Proventil HFA, generics). If none are formulary, approve.
Xpovio PID: 70907	selinexor tablets	**1.** Multiple Myeloma: Approve if the individual meets one of the following (i, ii, or iii): i. Individual has tried at least four prior regimens for multiple myeloma; OR ii. Individual meets both of the following (a and b): a) Individual has tried at least one prior regimen for multiple myeloma; AND b) The medication will be taken in combination with bortezomib; OR iii. Individual meets both of the following (a and b): a) Individual has tried at least one prior regimen for multiple myeloma; AND b) The medication will be taken in combination with Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Pomalyst (pomalidomide capsules). Note: Examples include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib infusion) / Revlimid/ dexamethasone, Darzalex (daratumumab injection)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody.

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		2. Diffuse Large B-Cell Lymphoma: approve if the individual has been treated with at least two prior systemic therapies. **3.** Multiple Myeloma, Diffuse Large B-Cell Lymphoma: If the individual has already been started on Xpovio, approve.
Xtampza ER PID: 55999	oxycodone extended-release capsules (with DETERx)	**1.** Approve if the individual has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or oxycodone ER tablets [generics]. **2.** Individual is intolerant or allergic to morphine: approve if the individual has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve. **3.** Individual has renal insufficiency: approve if the individual has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve.
Yosprala and authorized generic PID: 57335, 57408	aspirin and omeprazole delayed-release tablets	**1.** Approve if the individual has tried aspirin AND at least five proton pump inhibitors (e.g., omeprazole [Prilosec, generics], rabeprazole tablets [Aciphex, generics], lansoprazole [Prevacid, generics], esomeprazole [Nexium, generics], pantoprazole [Protonix, generics]).
Zcort PID: 59120	dexamethasone 1.5 mg tablets (7-day pack)	**1.** The individual is directed to use the dexamethasone 1.5 mg tablets (not packed as dose packs). If dexamethasone 1.5 mg tablets (not packaged as dose packs) are non-formulary, approve. Approval duration: 14 days
Zegerid capsules PID: 59999	omeprazole/ sodium bicarbonate capsules	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note:** The requested agent would NOT count as a trial of an alternative.
Zegerid packets PID: 60004	omeprazole/ sodium bicarbonate powder for oral suspension (packets)	**1.** Approve if the individual has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generics, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension.

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		Note: The requested agent would NOT count as a trial of an alternative.
Zelapar PID: 13226	selegiline orally disintegrating tablets	**1.** Approve if the individual has tried one product from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Azilect, generics), or Xadago. If none are formulary, approve. **2.** Approve if the individual cannot swallow or has difficulty swallowing selegiline tablets.
Zercapli and sertraline 150 mg, 200 mg capsules PID: 99407	sertraline 150 mg, 200 mg capsules	**1.** Direct the individual to sertraline tablets.
Zerviate PID: 80971	cetirizine 0.24% ophthalmic solution	**1.** Approve if the individual has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, or olopatadine solution (generics).
Zetonna PID: 13778	ciclesonide nasal aerosol	**1.** Approve if the individual has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, Beconase AQ, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Qnasl. **Note:** Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
zileuton extended-release tablets PID: 63444	zileuton extended-release tablets	**1.** Approve if the individual has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If none are formulary, approve.
Zilxi PID: 84286	minocycline 1.5% topical foam	**1.** Approve if the individual has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products from the following list: azelaic acid 15% gel (Finacea 15% gel, generics), Finacea 15% foam, Azelex 20% cream, sodium sulfacetamide 10%/sulfur 5% (Rosula, generics), metronidazole 0.75% or 1% (MetroGel, generics; MetroCream, generics; Lotion, generics), ivermectin cream (Soolantra, generics), or Noritate, if two are formulary, or one if only one is formulary. If none are formulary, approve.
Zimhi PID: 102244	naloxone hydrochloride intramuscular or subcutaneous injection 5 mg/0.5 ml	**1.** Approve if the individual has tried naloxone syringes, if formulary. If naloxone syringes are non-formulary, approve. **2.** Approve, if according to the prescriber, a higher-strength naloxone product is needed.
Zioptan PID: 13662	tafluprost 0.0015% ophthalmic solution	**1.** Approve if the individual has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), bimatoprost 0.03% ophthalmic solution (generics), travoprost

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		(Travatan Z, generics), Lumigan, Vyzulta, or Xelpros. If none are formulary, approve. **2.** Individual has a known sensitivity to the preservative benzalkonium chloride [BAK]: approve if the individual has tried travoprost (Travatan Z, generics), or Xelpros, if formulary. If neither are formulary, approve. **3.** Individual has a known sensitivity to preservatives other than benzaklonium chloride (BAK) [e.g., sofZia or potassium sorbate], approve.
Zipsor PID: 59122	diclofenac potassium capsule	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDS. **Note:** Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
zolmitriptan nasal spray (authorized generic of Zomig nasal spray) PID: 92920	zolmitriptan nasal spray	**1.** Direct the individual to Zomig nasal spray (brand), if formulary. If Zomig nasal spray (brand) is non-formulary, approve if the individual has tried one product from the following list (if one is formulary): sumatriptan nasal spray (Imitrex Nasal Spray, generics), Onzetra Xsail, or Tosymra Nasal Spray. If none are formulary, approve. **2.** Direct the individual to Zomig nasal spray (brand), if formulary. If Zomig nasal spray (brand) is non-formulary, approve if the individual is 12 to 17 years of age.
Zomacton (formerly Tev-Tropin) PID: 24536	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: **1.** Approve if the individual has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Saizen. If none are formulary, approve.
Zorvolex and authorized generic PID: 49394	diclofenac capsules	**1.** Approve if the individual has tried five prescription-strength, oral NSAIDS. **Note:** Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.

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Zyclara 2.5% and 3.75% and authorized generic 3.75% PID: 13391	imiquimod 2.5% and 3.75% cream	**1.** Approve if the individual has tried imiquimod 5% cream (Aldara, generics), if formulary. If imiquimod 5% cream (Aldara, generics) is non-formulary, approve.
Zyflo PID: 49785	zileuton tablets	**1.** Approve if the individual has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If neither are formulary, approve.
Zylet PID: 94577	tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension	**1.** Approve if the individual has tried one of tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics) or TobraDex ST, if formulary. If neither are non-formulary, approve. **2.** Individuals < 2 years of age, approve. **3.** For the treatment of currently active eye infections: approve in individuals already receiving Zylet to complete the course of therapy.

Conditions Not Covered

Any other exception is considered not medically necessary.