

PRIOR AUTHORIZATION

CRITERIA Effective

11/13/2026

DEPARTMENT OF HUMAN SERVICES

Nonpreferred Drug Prior Authorization Criteria

July 2025

Approval criteria

A request for coverage of a nonpreferred drug may be approved if the following criteria are met:

- The drug is not excluded from coverage (for example, drugs for erectile dysfunction) **AND**
- The drug is prescribed for a medically accepted indication as defined in Section 1927 of the Social Security Act **AND**
- The request is for an oral liquid form of a drug and the patient utilizes an enteral tube for feeding or medication administration **OR**
- The member has been taking the requested nonpreferred drug to treat a mental illness or emotional disturbance as defined by Minnesota Statute, 62Q.527 for at least 90 days **OR**
- The preferred drugs are experiencing documented drug shortages or recalls from a wholesaler, manufacturer, the ASHP (American Hospital of Health-System Pharmacist) Drug Shortage web page or the US Food and Drug Administration **OR**
- The requested drug is being prescribed within recommended dosing guidelines **AND**
- The member has had a trial of at least two preferred chemically unique drugs within the same drug class on the Preferred Drug List, or a trial of at least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class. The use of free goods or pharmaceutical samples will not be considered as meeting any step of the nonpreferred drug prior authorization criteria **AND (at least one of the following)**
    - The prescriber must provide documentation (for example, pharmacy dispensing record, medication orders in members' health record, and so forth) at the time of request showing that:
        - the member adhered to the previous therapies during the trial(s) AND
        - the trial period was sufficient to allow for a positive treatment outcome, or that the drug was discontinued due to an adverse event OR
    - The member is currently taking the requested nonpreferred drug and is experiencing a positive therapeutic outcome AND the prescriber provides documentation that switching the member to a preferred drug is expected to cause harm to the member, or that the preferred drug would be ineffective OR
    - The preferred drug is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information or, due to a documented adverse event or medical condition, is likely to result in the following:
        - cause an adverse reaction OR
        - decrease the ability of the member to achieve or maintain reasonable functional ability in performing daily activities OR
        - cause physical or mental harm to the member

Duration of Approval

- Requests due to drug shortages:
    - The Department of Human Services (DHS) may approve the request up to 3 months or up to the estimated known and verifiable resolution date, if the documented drug shortages are from the wholesaler (for example, wholesaler invoice, screenshot of wholesaler electronic ordering system, and so forth).
    - DHS may approve the request up to 6 months or up to the estimated known and verifiable resolution date, if the documented drug shortages are from the manufacturer (for example, manufacturer press release, screenshot of manufacturer web page, and so forth).

    - DHS may approve the request up to 12 months or up to the estimated known and verifiable resolution date, if the documented drug shortages are from the ASHP Drug Shortages web page or US Food and Drug Administration
- DHS may approve requests due to other reasons up to 12 months

Quantity Limits

- Quantity limits pursuant to the FDA-approved label will apply

Note

- If applicable, the nonpreferred drug prior authorization criteria does not replace the requirement for a clinical prior authorization for a specific drug
- The inability or unwillingness of the enrolled pharmacy to order or stock the preferred drug will not be considered as a basis for requests due to drug shortages

Definition

Free goods or pharmaceutical samples: medication samples, medications obtained from any patient assistance programs or any discount programs, medications obtained through free trial programs, manufacturer vouchers, coupons or debit cards while the member is on Medical Assistance.

For Questions

Provider Call Center: (844) 575-7887

DEPARTMENT OF HUMAN SERVICES

Continuation of Therapy Prior Authorization Criteria

February 2019

Definition:

Biosimilar Substitution: Dispensing a biosimilar product rather than the reference biologic product.

Cash Pay: Allowing a member to pay for the entire cost of a non-covered prescription, after a member, in consultation with the prescriber and the pharmacist, has decided that covered alternatives are not options. A member may pay for the entire cost of a non-covered controlled substance prescription, including gabapentin, only when the member meets all conditions specified in the Advanced Recipient Notice of Non-Covered Prescription Form (DHS-3641-ENG)

Continuation of Therapy: Allowing a member who has been stabilized on a medication that requires prior authorization, but was previously covered by another payer (i.e., commercial insurance, MCO Medicaid plans), to continue the therapy without the prescriber having to satisfy the Fee-for-Service prior authorization criteria.

Free goods/pharmaceutical samples: medication samples, medications obtained from any patient assistance programs, medications obtained through free trial programs, manufacturer vouchers, coupons or debit cards.

Generic Substitution: Dispensing a generically equivalent drug rather than the brand name drug.

Continuation of Therapy criteria:

Continuation of Therapy override may be approved for non-preferred or restricted drugs if the following conditions are met:

- The requested non preferred or restricted drugs are not excluded from coverage (e.g., drugs for weight loss, drugs for erectile dysfunction); AND
- The requested non-preferred or restricted drugs are prescribed for a medically accepted indication as defined in Sec. 1927 of the Social Security Act, AND
- The member has been treated with a non-preferred or restricted drugs at a consistent dosage for at least 90 days and the prescriber indicates (orally or in writing) that the prescribed medication will best treat the member's condition; AND
- The pharmacy or prescriber must provide an attestation that the medication was covered by another payer and not obtained via cash pay, drug manufacturer-issued debit cards, or via free goods/pharmaceutical samples.

Continuation of Therapy may be approved for the following duration:

- Continuation of Therapy override may be approved for up to 90 days. After 90 days, the prescriber must obtain prior authorization for the non-preferred or restricted drug or transition the member to an alternative therapy. Multiple Continuation of Therapy overrides will not be approved for the same drug; OR
- If the member has an existing approved prior authorization (PA) for the non-preferred or restricted drugs, then the member's previously approved PA will be approved until the PA expires; OR
- If the member has received a prescribed drug to treat a mental illness or emotional disturbance as defined by Minnesota Statute 62Q.527, the member may continue to receive coverage for such prescribed drugs for up to one year.

Continuation of Therapy criteria overrides are not available to bypass generic or biosimilar substitution (if applicable).

Free goods/Pharmaceutical Samples Policy:

The use of free goods or pharmaceutical samples will not be considered as meeting the 90-day treatment requirement for Continuation of Therapy overrides. A member, after meeting all conditions for cash pay, must pay for the entire cost of the non-covered prescription.

Prior Authorization Group Description	**Prior Authorization Exception Criteria**
Covered Uses	All medically accepted indications. Medically accepted indications are defined using the following compendia resources: the Food and Drug Administration (FDA) approved indication(s) (Drug Package Insert), American Hospital Formulary Service Drug Information (AHFS-DI), and DRUGDEX Information System. The reviewer may also reference disease state specific standard of care guidelines.
Scope	Requests for exception to the drug's prior authorization criteria requirements
Coverage Duration	12 months
Criteria	The provider either verbally or in writing has submitted a medical or member specific reason why prior authorization criteria all or in part is not applicable to the member. • Medical and/or member-specific reasons may include but are not limited to: o Uniqueness of the member's condition or other physical characteristics of the member's condition. o Psychiatric, intellectual, physical, cultural, and/or linguistic characteristics of the member which may prohibit the provider from obtaining all necessary prior authorization criteria requirements. **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Revision/Review Date:	11/2025

Prior Authorization Group Description	**Off-Label Uses**
Medications	Drugs with off-label uses
Covered Uses	Off-Label indications (medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer- reviewed published studies.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If the conditions are met, the request will be approved for 12 months (depending on the diagnosis and usual treatment duration).

Other Criteria
 	
Revision/ Review Date: 8/2026
	Documentation requirements for approval:
	• Drug is being requested at an appropriate dose per literature
	• One of the following:
	  o No other formulary drug has a medically accepted use for the member's specific diagnosis as referenced in the medical compendia
	  o Member has had a documented trial and or intolerance with two formulary medications used to treat the documented diagnosis, or for medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated
	• One of the following:
	  o Drug is being requested for an accepted off-label use listed in the standard clinical decision support resources (as noted in Covered Uses section above)
	  o Requested use can be supported by at least two published peer-reviewed clinical studies
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Quantity Limit Exception Criteria**
Covered Uses	All medically accepted indications. Medically accepted indications are defined using the following compendia resources: the Food and Drug Administration (FDA) approved indication(s) (Drug Package Insert), American Hospital Formulary Service Drug Information (AHFS-DI), and DRUGDEX Information System. The reviewer may also reference disease state specific standard of care guidelines.
Scope	Requests for formulary drugs exceeding the health plan's published quantity limits
Coverage Duration	12 Months
Criteria	• The provider has submitted justification for the approval of doubling (or higher) of the number of tablets/capsules per prescription for a medication that has a higher strength tablet/capsule available, stating why that higher dose tablet/capsule cannot be used (e.g. two lorazepam 0.5mg tablets to equal the dose of lorazepam 1mg, when lorazepam 1mg tablet exists). • The provider has submitted a medical reason why the plan's quantity limit will be inadequate based on the member's condition and treatment history. • **ONE of the following:** o The member has a documented treatment failure with the drug prescribed at the health plan's quantity limit AND the dose requested is supported by the Medical Compendia or current treatment guidelines. **OR** o The member requires a dose within prescribing guidelines that exceeds the plan's quantity limit. **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Revision/Review Date	11/2025

Prior Authorization Group Description	**Safety Edit Exception Criteria**
Covered Uses	All medically accepted indications. Medically accepted indications are defined using the following compendia resources: the Food and Drug Administration (FDA) approved indication(s) (Drug Package Insert), American Hospital Formulary Service Drug Information (AHFS-DI), and DRUGDEX Information System. The reviewer may also reference disease state specific standard of care guidelines.
Scope	Requests for formulary drugs and for previously approved non-formulary drugs: • Exceeding the Food and Drug Administration (FDA) or compendia max dose recommendations • Exceeding the FDA dosing or compendia administration frequency recommendations • Exceeding the FDA or compendia duration of therapy recommendations • Duplication of therapy error at Point of Service (POS) • Age Restriction error at POS • Day Supply Limit error at POS • Concurrent Use error at POS • Drug Drug Interaction error at POS
Coverage Duration	*One month approval for Duplication of therapy when transitioning from one agent to another and Day Supply Limit due to a dose increase. All Other Scenarios: 12 months
Criteria	**Exceeding the Food and Drug Administration (FDA) or compendia maximum dose, administration frequency or duration of therapy recommendations.** • The member must have a documented treatment failure with the drug at the maximum dose based on patient age/weight, administration frequency, or duration of therapy per FDA or compendia. AND • The provider must submit a medical reason why the maximum dose, administration frequency or duration of therapy needs to be exceeded based on the member's condition or treatment history. **Duplication of therapy** <u>Transition from one agent to another</u> • If a provider has outlined a plan to transition a member to a similar drug or provided a dose titration schedule, the requested drug is approved for one month*. <u>Concurrent Therapy with two similar agents</u>

	• The provider must submit a medical reason why treatment with more than one drug in the same class is required based on the member's condition and treatment history. OR • The provider must submit disease state specific standard of care guidelines supporting concurrent therapy. **Age Restriction** • The provider must submit a medical reason why the drug is needed for a member whose age is outside of the plan's minimum or maximum age limit. AND • The indication and dose requested is supported by the Medical Compendia or current treatment guidelines. **<u>Day Supply Limit</u>** • An additional fill exceeding the day supply limit is needed based on a dose increase or is needed to achieve a total daily dose OR • The provider must submit a medical reason why an additional fill is needed outside of the plan's day supply limit. AND • The indication and dose requested is supported by the FDA, Medical Compendia or current treatment guidelines. **<u>Concurrent Use/Drug-Drug Interaction</u>** • The provider must submit a medical reason why treatment with both drugs is necessary for the member AND • The increased risk for side effects when taking the drugs together has been discussed with the member **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Revision/Review Date:	11/2025

Prior Authorization Group Description	**Specialty Drugs**
Drugs	Oral and injectable specialty drugs without drug or class specific prior authorization criteria *** The Oncology Drugs/Therapies prior authorization criteria will be applied to oncology drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, requests will be approved for 6 months.
Other Criteria Revision/Review Date: 8/2026	• The drug is being requested for an appropriate use (per the references outlined in "Covered Uses") • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • If the request is for a non-formulary/non-preferred drug, documentation has been provided that the member has tried and failed two formulary/preferred agents appropriate for the requested use (per the references outlined in "Covered Uses") or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication) • If the request is for a reference biologic drug with a biosimilar or interchangeable biologic drug, documentation of one of the following: o The provider has verbally, or in writing, submitted a member-specific reason why the reference biologic is required based on the member's condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. MedWatch form must also be included with the prior authorization request. Form FDA 3500 – Voluntary Reporting o The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors**
Drugs	Nexletol (bempedoic acid), Nexlizet (bempedoic acid/ezetimibe), or any newly-approved drug in the class
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by a cardiologist or specialist in the treatment of lipid disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 3 months. Reauthorization requests will be approved for 12 months.
Other Criteria Revision/Review Date: 5/2026	**<u>Initial Authorization:</u>** All requests: • Member must have documentation of baseline low density lipoprotein cholesterol (LDL-C) • Member has tried and failed a high-intensity statin (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes or documentation has been provided that the member is not able to tolerate a statin. • Documentation was provided indicating provider has counseled member on smoking cessation and following a "heart healthy diet". For Hyperlipidemia: • Member meets ONE of the following: o Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) o Member has a diagnosis of primary hyperlipidemia • Member has tried and failed ezetimibe at a maximum tolerated dose and LDL-C is not at goal, or documentation has been provided that the patient is not able to tolerate ezetimibe. For Cardiovascular Risk Reduction: • Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral arterial disease, and or cerebrovascular atherosclerotic disease) • Member has a fasting LDL-C ≥ 55 mg/dL • Member does not have established cardiovascular disease (ASCVD) but is considered high risk (one of the following): o Diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age o A Reynolds Risk score > 30% or a SCORE Risk score > 7.5% over 10 years o A coronary artery calcium score >400 Agatston units at any time in the past.

	<u>Reauthorization:</u> • Documentation was provided that the member has experienced a clinical benefit from the medication (e.g., LDL-C lowering from baseline) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Acute Migraine Treatments**
Drugs	Preferred: Ubrelvy (ubrogepant) Non-preferred: Reyvow (lasmiditan) Symbravo (meloxicam and rizatriptan) Nurtec ODT (rimegepant) - If the request is for migraine prevention please refer to the Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention criteria Zavzpret (zavegepant)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member is 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, migraine specialist, pain specialist, or other specialist in the treatment of headaches
Coverage Duration	If all of the criteria are met, the initial request will be approved for 3 months. For reauthorization requests, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 11/2026	**Initial Authorization:** • Diagnosis of migraine headache • Requested dose is within FDA approved dosing guidelines • Documented trial and failure of (or medical justification for not using) an analgesic medication and two triptan products • If the request is for a non-preferred medication, documentation of trial/failure of, or a medical justification for not using, Ubrelvy. • Reyvow only: Attestation the patient was counseled regarding not driving or operating machinery until at least 8 hours after taking each dose **Criteria for Re-Authorization:** • Documentation of improvement in migraine pain and symptom(s) (e.g., photophobia, nausea, phonophobia) **Reyvow QL of 8 units per month.** **Ubrelvy QL of 16 units per month** **Nurtec ODT QL of 15 units per month** **Zavzpret QL of 8 units per month** **Criteria for exceeding the quantity limit (note all of the above criteria must also be met)** • Documented trial and failure (or a medical justification for not using e.g. hypersensitivity, baseline bradycardia or hypotension, adverse events experienced from previous trial, etc.) with at least one drug from two categories below for at least 4 weeks EACH, at minimum effective doses:

	o Beta-adrenergic blockers o Topiramate or divalproex ER or DR o Amitriptyline or venlafaxine o Frovatriptan, zolmitriptan, or naratriptan (for menstrual migraine prophylaxis) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Adakveo (crizanlizumab-tmca)**
Drugs	Adakveo (crizanlizumab-tmca)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restriction	Member must be 16 years of age or older
Prescriber Restriction	Prescribed by a hematologist or provider with expertise in the treatment of sickle cell disease
Coverage Duration	If all of the criteria are met, the initial request may be approved for up to a 6-month duration. Reauthorization requests may be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 05/2026
	Initial Authorization:
	• Member has a confirmed diagnosis of sickle cell disease
	• Documentation was provided that the member has had 2 or more pain crises in the last 12 months
	• Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose and has been compliant within the last 6 months (or a medical reason was provided why the patient is unable to use hydroxyurea)
	• Documentation of the member's current weight
	• Request is for an FDA-approved dose
	
	Reauthorization:
	• Documentation has been submitted that the member has demonstrated or maintained ONE of the following changes from baseline:
	  ○ Reduction in pain crises
	  ○ Increased time between crises
	  ○ Decrease in days hospitalized
	• Documentation of the member's current weight
	• Request is for an FDA-approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Adrenal Enzyme Inhibitors for Cushing's Syndrome**
Drugs	Recorlev (levoketoconazole), Isturisa (osilodrostat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Patients with a non-endogenous source of hypercortisolism, such as exogenous source of glucocorticoids or therapeutic use of ACTH. • Patient has a diagnosis of pituitary or adrenal carcinoma
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA approved package insert
Prescriber Restrictions	Prescriber must be an endocrinologist or in consultation with an endocrinologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 2/2026
	<u>Initial Authorization:</u>
	• Patient has a diagnosis of endogenous Cushing's syndrome.
	• Patient is not a candidate for surgery, surgery is not an option, or prior surgery has not been curative.
	• Documented baseline urinary free cortisol (UFC) test ≥ 1.3 times ULN (within the past 30 days).
	• Medication is prescribed at an FDA approved dose.
	• For Isturisa, provider must also attest that baseline electrocardiogram (ECG) has been obtained and hypokalemia and/or hypomagnesemia has been corrected prior to initiating therapy if present
	• Member has had a documented trial and failure of one of the following:
	  o ketoconazole
	  o Metopirone (metyrapone)
	  o Lysodren (mitotane)
	  o cabergoline
	  o Signifor/Signifor LAR (pasireotide)
	  o etomidate
	• OR
	• Member has a documented medical reason (e.g. contraindication, intolerance, hypersensitivity) as to why these medications cannot be used

	<u>Re-Authorization:</u> • Documentation or provider attestation of positive clinical response (i.e. decrease in urinary free cortisol from baseline.) • Medication is prescribed at an FDA approved dose **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Field Name	Field Description
Prior Authorization Group Description	**Adzynma**
Drugs	Adzynma (ADAMTS13, recombinant-krhn)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, intensive care specialist, or specialist in the treatment of rare genetic hematologic diseases
Coverage Duration	On-demand therapy: If all criteria are met, the request will be approved for 1 month. Prophylactic therapy: If all criteria are met, the initial request will be approved for 6 months. Reauthorization requests will be approved for 12 months.

Other Criteria	**Initial Authorization**
	• Diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP) as confirmed by BOTH of the following:
	  o Molecular genetic testing
	  o ADAMTS13 activity <10%
	• Prescriber attestation that member has not been diagnosed with any other TTP-like disorder (i.e., microangiopathic hemolytic anemia, immune-mediated thrombotic thrombocytopenic purpura [iTTP])
	• If request is for prophylactic therapy, member must also have a history of at least one documented TTP event
	• Member's weight
	• Request is for an FDA-approved dose
	
	Reauthorization
	• Documentation of positive clinical response to therapy (i.e., improvement in acute and subacute TTP events, platelet counts, microangiopathic hemolytic anemia episodes, or clinical symptoms)
	• Member's weight
	• Request is for an FDA-approved dose

Revision/Review Date: 2/2026	**Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Agents for Atopic Dermatitis**
Drugs	<u>Preferred:</u> Dupixent (dupilumab) tacrolimus ointment pimecrolimus cream Eucrisa (crisaborole) <u>Non-preferred/Non-formulary:</u> Opzelura (ruxolitinib) Rinvoq (upadacitinib) Adbry (tralokinumab) Cibinqo (abrocitinib) Protopic ointment (BRAND) Elidel cream (BRAND) Zoryve 0.05%, 0.15% (roflumilast) cream Ebglyss (lebrikizumab-lbkz) Vtama (tapinarof)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Tacrolimus (Protopic), pimecrolimus (Elidel), and Opzelura should not be used in immunocompromised patients
Required Medical Information	See "other criteria"
Age Restrictions	Per prescribing information
Prescriber Restrictions	Prescribed by a pediatrician, dermatologist, immunologist, or allergist
Coverage Duration	For Opzelura, Zoryve, and Vtama: Initial requests will be approved for 8 weeks and reauthorization requests will be approved for 6 months. For all other products: Requests will be approved for 6 months and reauthorization requests will be approved for 12 months.
Other Criteria	**<u>Initial Authorization</u>** For non-preferred medications, a trial and failure of a preferred agent is required in addition to the criteria below **For pimecrolimus (Elidel) and tacrolimus (Protopic):** • Trial and failure of one formulary medium to high potency topical corticosteroid **For Eucrisa, Vtama, Opzelura and Zoryve 0.05%, 0.15% cream:** • Diagnosis of mild to moderate atopic dermatitis • Trial and failure of, contraindication to, intolerance to, or medical reason for not using the following: o A formulary medium to high potency topical corticosteroid AND o tacrolimus (Protopic) or pimecrolimus (Elidel) (not required for members less than 2 years of age) **A MAXIMUM OF ONE 60g TUBE PER WEEK OR ONE 100g TUBE PER 2 WEEKS OF OPZELURA MAY BE APPROVED** **For Dupixent:** o Diagnosis of moderate to severe atopic dermatitis o Trial and failure of, contraindication to, intolerance to, or medical reason for not using the following: o A formulary medium to high potency topical corticosteroid AND o Topical tacrolimus (Protopic) or pimecrolimus (Elidel) AND

Revision/Review Date: 8/2026	**For Nemluvio or Adbry:**
	• Diagnosis of moderate to severe atopic dermatitis
	• Trial and failure of, contraindication to, intolerance to, or medical reason for not using ONE of the following:
	  o Eucrisa
	  o Opzelura
	  o Vtama
	  o Zoryve
	
	For Rinvoq or Cibinqo:
	• Diagnosis of refractory, moderate to severe atopic dermatitis
	• Trial and failure of, intolerance to, or contraindication to another systemic immunomodulatory drug product for atopic dermatitis
	
	For Ebglyss:
	• Diagnosis of moderate to severe atopic dermatitis
	• Trial and failure of, or contraindication to, ONE of the following:
	  o Adbry
	  o Dupixent
	  o Nemluvio
	
	Reauthorization:
	• Provider attests that the member has experienced improvement in symptoms (e.g. significant clearing of the skin, reduction in itching) due to the medication
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Agents for Thrombocytopenia**
Drugs	Non-formulary: • Nplate (romiplostim) • Doptelet (avatrombopag) • Tavalisse (fostamatinib) • eltrombopag (Promacta) • Mulpleta (lusutrombopag) • Alvaiz (eltrombopag) • Wayrilz (rilzabrutinib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a hematologist
Coverage Duration	• If the criteria are met, the request will be approved for 12 months for eltrombopag, Alvaiz, Nplate ,Tavalisse, and Wayrilz. • Doptelet will be approved for a maximum of 5 days for thrombocytopenia associated with chronic liver disease in adult patients requiring elective surgery and 12 months for immune thrombocytopenia (ITP) • Mulpleta will be approved for a maximum of 7 days.

Other Criteria	• **Chronic immune (idiopathic) thrombocytopenia (ITP):**
	  • Platelet level < 30,000 mm^3
	  • Documented trial and failure, intolerance or contraindication to use ONE of the following:
	  ▪ Glucocorticoids
	  ▪ Intravenous immune globulin (IVIG),
	  ▪ Rituximab
	  ▪ Splenectomy
	  • If the request is for Nplate, Doptelet, Alvaiz, Tavalisse, or Wayrilz, the member has a documented trial and failure, intolerance, or contraindication to eltrombopag
	
	• **Severe aplastic anemia** (eltrombopag and Alvaiz only):
	  • Documented trial and failure, intolerance or contraindication to use at least one immunosuppressive agent
	  • Platelet level < 20,000 cells/microL OR platelet level < 30,000 cells/microL with bleeding OR reticulocyte level < 20,000 cells/microL OR absolute neutrophil level < 500 cells/microL
	  • For Alvaiz, member must also have a documented trial and failure, intolerance, or contraindication to eltrombopag
	
	• **Thrombocytopenia in patients with Hepatitis C infection**

Revision/Review Date: 8/2026	(eltrombopag and Alvaiz only): • Diagnosis of chronic hepatitis C • Documentation of treatment with interferon-based therapy AND patient's degree of thrombocytopenia prevents the initiation or limits the ability to maintain interferon-based therapy • Medical reason for why patient needs to be treated with interferon over direct acting antiviral (DAA) medication • Platelet level < 50,000/mm^3 • For Alvaiz, member must also have a documented trial and failure, intolerance, or contraindication to eltrombopag • **Thrombocytopenia associated with chronic liver disease in *adult* patients requiring elective surgery** (Doptelet and Mulpleta only): • Patient has a diagnosis of chronic liver disease and is scheduled to undergo a procedure • Platelet level < 50,000/mm^3 • **For Mulpleta:** documentation of trial and failure, intolerance, or contraindication to use Doptelet **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Agents to Treat Constipation**
Drugs	**Preferred:** lubiprostone (Amitiza) Linzess (linaclotide) prucalopride (Motegrity) **Non-Preferred, PA Required:** Trulance (plecanatide) Symproic (naldemedine) Ibsrela (tenapanor) Movantik (naloxegol) Amitiza (lubiprostone) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for a 6 month duration. If all of the criteria are met, the reauthorization request will be approved for a 12 month duration.
Other Criteria	**Initial Authorization Criteria:** **For chronic idiopathic constipation (CIC), functional constipation, or irritable bowel syndrome with constipation (IBS-C) or pediatric functional constipation, all of the following apply:** • The member has a diagnosis of CIC, IBS-C, or pediatric functional constipation • The member has tried and failed 2 different laxatives from 2 different classes (bulk-forming, osmotic, stimulant) • The medication is prescribed at an FDA-approved dose • If the request is for a non-preferred agent, the member must also have a trial and failure of (or medical reason for not using) ONE preferred product for the requested indication (note: lubiprostone is only indicated in **women** with IBS-C) **For opioid induced constipation (OIC), all of the following apply:** • The member has a diagnosis of OIC with chronic, non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation OR the member has a diagnosis of OIC with advanced illness • The member has tried and failed 2 different laxatives from 2

Revision/Review Date: 11/2026	different classes (bulk-forming, osmotic, stimulant) • The medication is prescribed at an FDA-approved dose • If the request is for a non-preferred agent, the member must also have a trial and failure of (or medical reason for not using) ONE preferred products for the requested indication **Reauthorization Criteria**: • The member has been adherent with therapy (as determined through review of claims history) • Documentation that the member has experienced treatment efficacy • The medication is prescribed at an FDA-approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Agents to Treat Gaucher Disease**
Drugs	Cerdelga (eliglustat tartrate), Cerezyme (imiglucerase), Vpriv (velaglucerase alfa), Elelyso (taliglucerase alfa), miglustat (Zavesca)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a specialist in treatment of Gaucher Disease (e.g. hematologist, orthopedist, endocrinologist, or geneticist).
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 05/2026	**Initial Authorization:** • Request is for an FDA-approved dose Vpriv, Elelyso, or miglustat: • Member has a confirmed diagnosis of Gaucher disease, type 1 (GD1) Cerezyme: • Patient has a confirmed diagnosis of a non-central nervous system (CNS) manifestation of Gaucher disease, type 1 or type 3 Cerdelga: • Member has a confirmed diagnosis of Gaucher disease, type 1 • The member has been designated a Cytochrome P450 2D6 (CYP2D6) extensive metabolizer (EM), intermediate metabolizer (IM) or poor metabolizer (PM) as detected by an FDA-approved test. • Member is not concomitantly taking a Class IA (e.g., quinidine, procainamide) or Class III (e.g., amiodarone, sotalol) antiarrhythmic. • For EMs or IMs, member is not concomitantly taking a moderate or strong CYP2D6 inhibitor (e.g., fluoxetine, bupropion) WITH a moderate or strong Cytochrome P450 3A (CYP3A) inhibitor (fluconazole, ketoconazole). • For IMs and PMs, member is not concomitantly taking a strong CYP3A inhibitor • For EMs, patient does not have moderate or severe hepatic impairment • For IMs or PMs, patient does not have any degree of hepatic impairment

	• Patient has no pre-existing cardiac disease or long QT syndrome. **<u>Re-Authorization criteria for all agents:</u>** • Documentation has been provided that member has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, pulmonary function tests (PFTs), improvement in radiographic scans, improved quality of life) • Request is for an FDA-approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Agents for graft versus host disease**
Drugs	**<u>Non-preferred/Non-formulary</u>** Imbruvica (ibrutinib) Jakafi (ruxolitinib) Rezurock (belumosudil) Orencia (abatacept) Ryoncil (remestemcel-L-rknd) Niktimvo (axatilimab-csfr)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per prescribing information
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or other specialist in the treatment of hematopoietic cell transplants
Coverage Duration	Jakafi, Niktimvo, Rezurock, and Imbruvica: If all of the conditions are met, the request will be approved for up to a 3 month duration for initial requests and up to a 6 month duration for renewal requests. Orencia: If all the conditions are met, the request will be approved for a 1 month duration (4 total infusions) Ryoncil: If all of the criteria are met, the initial request will be approved for a 2 month duration (12 infusions total). If all of the criteria are met, the reauthorization request will be approved for a 1 month duration (8 total infusions)
Other Criteria	**<u>**For oncological indications, please refer to the "Oncology Agents" policy**</u>** **<u>Initial Authorization:</u>** • Imbruvica o Member has a diagnosis of chronic graft versus host disease o Member has tried and failed or cannot use a systemic corticosteroid or immunosuppressant, or documentation is provided as to why a systemic corticosteroid or immunosuppressant cannot be used o The drug is prescribed at an FDA-approved dose • Jakafi o Member has a diagnosis of acute graft versus host disease or a diagnosis of chronic graft versus host disease o Member has tried and failed or cannot use a systemic corticosteroid or documentation is provided as to why a systemic corticosteroid cannot be used

Revision/Review Date: 5/2026	○ The drug is prescribed at an FDA-approved dose • Rezurock or Niktimvo ○ Member has a diagnosis of chronic graft versus host disease ○ Member has tried and failed at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, calcineurin inhibitors, mycophenolate mofetil, ibrutinib, ruxolitinib), one of which must be a systemic corticosteroid, or documentation is provided as to why a systemic corticosteroid cannot be used ○ The drug is prescribed at an FDA-approved dose • Orencia ○ Orencia is being requested for prophylaxis against acute graft versus host disease ○ Member will be underdoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor ○ Member will be receiving Orencia in combination with a calcineurin inhibitor (e.g., tacrolimus, cyclosporine,) and methotrexate ○ Member will be receiving antiviral prophylactic treatment for Epstein-Barr virus reactivation and will continue for 6 months following HSCT ○ Attestation provider has considered prophylactic antivirals for cytomegalovirus (CMV) infection/reactivation during treatment and for 6 months following HSCT ○ The drug is prescribed at an FDA-approved dose • Ryoncil ○ Member has a diagnosis of acute graft versus host disease ○ Member has tried and failed or cannot use a systemic corticosteroid or documentation is provided as to why a systemic corticosteroid cannot be used ○ Member's weight ○ Medication is prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • Documentation is provided that the member has achieved a clinical benefit from medication (e.g. symptom improvement, reduction in corticosteroid dose) • For Ryoncil requests: documentation is provided that member has a recurrence of GvHD after achieving a complete response with initial therapy of Ryoncil • The drug is prescribed at an FDA-approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Agents for Primary Biliary Cholangitis**
Drugs	Iqirvo (elafibranor), Livdelzi (seladelpar)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restriction	Member must be 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	If all of the criteria are met, the request will be approved for a 3 month duration for initial authorization and for up to a 12 month duration for reauthorization.

Other Criteria
 	
Revision/Review Date: 11/2025
	Initial Authorization:
	• Diagnosis of primary biliary cholangitis (PBC) confirmed by at least two of the following:
	  o Positive antimitochondrial antibody (AMA) test, or presence of other PBC-specific autoantibodies, including sp100 or gp210, if AMA test is negative
	  o Elevated serum alkaline phosphatase (ALP) level
	  o Histological evidence of PBC from a liver biopsy
	• Drug is being added to ursodeoxycholic acid (UDCA) due to inadequate response for at least 1 year; OR member has a documented medical reason (e.g., contraindication, intolerance, hypersensitivity) and is taking the requested drug as monotherapy
	• Prescriber attests the member does not have complete biliary obstruction or decompensated cirrhosis (e.g. Child-Pugh Class B or C)
	• Submission of the following test results within 30 days of request:
	  o Serum alkaline phosphatase (ALP)
	  o Total bilirubin
	
	Reauthorization:
	• Submission of lab tests confirming each of the following:
	  o A decrease in ALP of ≥ 15% from baseline
	  o ALP is less than 1.67 times the upper limit normal (ULN); defined as 118 U/L for females and 124 U/L for males
	  o Total bilirubin ≤ ULN defined as 1.1 mg/dL for females and 1.5 mg/dL for males
	• Prescriber attests that the member has not developed complete biliary obstruction or decompensated cirrhosis (e.g. Child-Pugh Class B or C)
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary

Field Name	Field Description
Prior Authorization Group Description	Agents for the Treatment of Postpartum Depression
Drugs	Zurzuvae (zuranolone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a psychiatrist or an obstetrician-gynecologist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for a one 14-day course of Zurzuvae per postpartum period. Reauthorization will not be permitted.
Other Criteria Review/Revision Date: 02/2026	• Physician attestation of moderate to severe postpartum depression (PPD) diagnosis and submission of validated screening tool result(s) (e.g., Edinburgh Postnatal Depression Scale, Hamilton Depression Rating Scale) that requires quick onset where the patient cannot wait 4-6 weeks for the standard of care antidepressants to take effect • Patient is ≤ 6 months postpartum with a major depressive episode without psychosis that began no earlier than the third trimester and no later than the first 4 weeks after delivery • Attestation that the provider warned the patient not to drive for at least 12 hours after each dose . • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Anzupgo (delgocitinib)**
Drugs	Anzupgo
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Current use of Opzelura (ruxolitinib), systemic JAK inhibitors, or potent immunosuppressants
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	None
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Review/Revision Date: 11/2025	**<u>Initial Authorization:</u>** • Medication is prescribed at an FDA approved dose • Diagnosis of moderate to severe chronic hand eczema (CHE) • Documentation of hand eczema persisting for >3 months or recurring ≥2 times within 12-month time frame • Trial and failure, or contraindication to, ≥2 formulary moderate/high-potency topical corticosteroids **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e. significant clearing of the skin, reduction in itching) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Amifampridine**
Drugs	Firdapse (amifampridine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a neuromuscular specialist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 02/2026	**<u>Initial Authorization:</u>** • Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) based on at least one electrodiagnostic study (i.e., repetitive nerve stimulation, nerve conduction studies, electromyography) OR anti-P/Q-type voltage-gated calcium channel antibody testing • Member has been screened for small cell lung cancer (SCLC) and/or other malignancies • Member does not have a history of seizures • Medication is being prescribed at a dose that is FDA-approved or is supported by compendia or standard of care guidelines **<u>Re-authorization:</u>** • Medication is being prescribed at a dose that is FDA-approved or is supported by compendia or standard of care guidelines • Documentation that prescriber has evaluated the member and recommends continuation of therapy **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Amtagvi (lifileucel)**
Drugs	Amtagvi (lifileucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Uncontrolled brain metastases • Melanoma of uveal or ocular origin • Systemic steroid therapy for any reason
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	If all of the criteria are met, the request will be approved for a one-time treatment.
Other Criteria Review/Revision Date: 05/2026	• Diagnosis of unresectable or metastatic melanoma (Stage IIIc or Stage IV) • Member must have progressed through at least one prior systemic therapy including a PD-1/PD-L1 blocking antibody and, if BRAF V600 mutation–positive, a BRAF inhibitor or BRAF inhibitor in combination with a MEK inhibitor • Member must have at least one resectable lesion (or aggregate of lesions resected) of a minimum 1.5 cm in diameter post-resection • Eastern Cooperative Oncology Group (ECOG) score of 0 or 1 • Medication is prescribed at an FDA approved dose **The safety and effectiveness of repeat administration of Amtagvi has not been evaluated and will not be approved.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Androgenic Agents**
Drug(s)	Preferred (PA required): testosterone cypionate intramuscular oil testosterone (generic Androgel) 1.62% transdermal gel pump Testim (testosterone) 1% gel testosterone (Vogelxo AG) 1% (50 mg/5 g) transdermal gel packet, 12.5 mg/actuation pump Androgel 1.62% transdermal gel pump Non-preferred (PA required): testosterone (generic Androgel) 1.62% transdermal gel packet testosterone (generic Androgel) 1% transdermal gel packet Vogelxo 1% (50 mg/5 g) transdermal gel packet, 12.5 mg/actuation pump methyltestosterone 10 mg capsule testosterone 2% transdermal gel pump Methitest (methyltestosterone) 10 mg tablet Aveed (testosterone) 750 mg/3 ml (250 mg/ml) intramuscular solution Testopel (testosterone) 75 mg implant pellet testosterone enanthate 200 mg/ml intramuscular oil Xyosted (testosterone) subcutaneous auto-injector Jatenzo (testosterone undecanoate) capsules Tlando (testosterone undecanoate) capsules Or any newly marketed testosterone agent Non-formulary Androgel 1.62% transdermal gel packet testosterone (Axiron) 30 mg/actuation transdermal solution in metered pump Natesto (testosterone) 5.5 mg/0.122 g/actuation nasal gel pump Kyzatrex (testosterone undecanoate) capsules Azmiro (testosterone cypionate) intramuscular syringe
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) and the Drug Package Insert).
Exclusion Criteria	N/A
Required Medical Information	See “other criteria”
Age Restrictions	None
Prescriber	None
Coverage Duration	Initial authorization: 3 months Reauthorization duration: 12 months

Other Criteria Revision/Review Date: 8/2026	Initial Authorization: • Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (secondary hypogonadism) • Documented total testosterone level less than 300 ng/dl on two occasions in the last 18 months (copies of laboratory results required) • If a non-preferred drug is being requested, the member has had a trial of at least two preferred chemically unique drugs within the same drug class, or a trial of at least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class; or documentation was provided as to why the member cannot use preferred drugs Re-Authorization: • Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). • Documentation indicating the member has experienced a clinical benefit as a result of therapy **Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Anti-CD19 CAR-T Immunotherapies**
Drugs	Breyanzi (lisocabtagene maraleucel), Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel), Aucatzyl (obecabtagene autoleucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Kymriah, Breyanzi: Patients with primary central nervous system lymphoma
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescriber must be an oncologist, hematologist or other appropriate specialist.
Coverage Duration	If all the criteria are met, the initial request will be approved for a single treatment regimen per lifetime. • Kymriah, Yescarta, Tecartus, Breyanzi: a one-time infusion • Aucatzyl: a split-dose infusion administered on day 1 and day 10 (± 2 days)
Other Criteria	**<u>Initial authorization:</u>** • Patient must not have received prior anti-CD19 CAR-T therapy. • Patient will be screened for HBV, HCV, and HIV in accordance with clinical guidelines. • Patient does not have an active infection or inflammatory disorder. • Patient has a life expectancy >12 weeks. • Patient will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment. • Use is supported by a labeled indication or NCCN guidelines. **<u>Leukemia</u>** **B-cell precursor Acute Lymphoblastic Leukemia (ALL):** • If the request is for Kymriah o Patient is 25 years of age or younger o ALL that is refractory or in second or later relapse • If the request is for Tecartus or Aucatzyl o Patient is 18 years of age or older o ALL that is relapsed or refractory **Chronic Lymphocytic Leukemia (CLL):** • If the request is for Breyanzi o Member is 18 years of age of older o Member has relapsed/refractory disease defined as failure of two or more lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor AND a B-cell lymphoma 2 (BCL-2) inhibitor **<u>Non-Hodgkin's Lymphoma (NHL)</u>** **Follicular Lymphoma (FL):**

Revision/Review Date: 05/2026	• If the request is for Breyanzi, Kymriah, or Yescarta:
	  o Member is 18 years of age or older
	  o Member has relapsed/refractory disease defined as failure of two or more lines of systemic therapy
	
	Large B-cell Lymphoma (LBCL), Diffuse Large B-cell Lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, follicular lymphoma grade 3B, and DLBCL arising from follicular lymphoma or indolent lymphoma:
	• If the request is for Breyanzi (lisocabtagene maraleucel), Kymriah (tisagenlecleucel), or Yescarta (axicabtagene ciloleucel):
	  o Member is 18 years of age or older
	  o For Breyanzi, member meets ONE of the following:
	  ▪ Member is refractory to first-line chemoimmunotherapy or relapsed within 12 months of first-line chemoimmunotherapy
	  ▪ Member is refractory to first-line chemoimmunotherapy or relapsed after first-line chemoimmunotherapy and is not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age
	  ▪ Member has relapsed or refractory disease after two or more lines of systemic therapy
	  o For Kymriah: Member has relapsed/refractory disease defined as failure of two or more lines of systemic therapy
	  o For Yescarta: Member is refractory to first-line chemoimmunotherapy or relapses within 12 months of first-line chemoimmunotherapy OR has failed two or more lines of systemic therapy.
	
	Mantle Cell Lymphoma (MCL):
	• Patient is 18 years of age or older
	• If the request is for Tecartus:
	  o Patient has relapsed/refractory disease defined as failure of all of the following lines of therapy:
	  ▪ Chemoimmunotherapy such as an anti-CD20 monoclonal antibody (e.g. Rituxan) + any chemotherapeutic agent
	  ▪ Bruton Tyrosine Kinase (BTK) Inhibitor (e.g. Calquence, Imbruvica, Brukinsa)
	• If the request is for Breyanzi:
	  o Patient has relapsed or refractory disease who have received at least 2 prior lines of systemic therapy, including a BTK inhibitor
	
	For Small Lymphocytic Lymphoma (SLL):
	• If the request is for Breyanzi
	  o Patient is 18 years of age or older
	  o Patient has received at least 2 prior lines of therapy including, a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor
	Marginal Zone Lymphoma (MZL):
	• If the request is for Breyanzi:
	  o Patient is 18 years of age or older
	  o Patient has relapsed or refractory disease and have received at least 2 prior lines of systemic therapy

	<u>Re-authorization</u>:
	
	• Treatment exceeding a single treatment regimen per lifetime will not be authorized.
	  o Kymriah, Yescarta, Tecartus, Breyanzi :a one-time infusion
	  o Aucatzyl: a split-dose infusion administered on day 1 and day 10 (± 2 days)
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Anti-FGF23 Monoclonal Antibodies**
Drugs	Crysvita (burosumab) SQ solution, or any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: The Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	X-linked hypophosphatemia (XLH): 6 months of age or older Tumor-induced osteomalacia (TIO): 2 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, nephrologist, molecular geneticist, or other specialist experienced in the treatment of metabolic bone disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months and reauthorization requests will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 05/2026
	<u>Initial Authorization:</u>
	
	For X-linked hypophosphatemia (XLH):
	• Diagnosis of XLH
	• Dosing is appropriate as per labeling or is supported by compendia or standard of care guidelines
	• Labs, as follows:
	  o Serum phosphorus below normal for patient age
	  o eGFR > 30 mL/min/1.73 m2 or CrCl ≥ 30 mL/min
	• Patient will not use concurrent oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol)
	• For adults:
	  o Clinical signs and symptoms of XLH (e.g., bone/joint pain, fractures, osteomalacia, osteoarthritis, ensethopathies, spinal stenosis impaired mobility, presence or history of lower limb deformities, etc.)
	
	For tumor-induced osteomalacia (TIO):
	• Diagnosis of FGF23-related hypophosphatemia in TIO
	• Dosing is appropriate as per labeling or is supported by compendia or standard of care guidelines
	• The tumor(s) is/are not amenable to surgical excision or cannot be located
	• Labs, as follows:
	  o Serum phosphorus below normal for patient age
	  o eGFR > 30 mL/min/1.73 m2 or CrCl ≥ 30 mL/min
	• Patient will not use concurrent oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol)
	
	<u>Re-authorization:</u>
	
	For XLH or TIO:
	• Documented effectiveness as evidenced by at least ONE of the following:

	○ Serum phosphorus within normal limits for patient age ○ Clinical improvement (e.g. improved rickets, improved bone histomorphometry, increased growth velocity, increased mobility, decrease in bone fractures, improved fracture healing, reduction in bone-related pain) • 25-hydroxyvitamin D level and, if abnormally low, documented supplementation with cholecalciferol or ergocalciferol • Patient is not concurrently using oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol) • Dosing continues to be appropriate as per labeling or is supported by compendia or standard of care guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Antifibrotic Respiratory Tract Agents**
Drug(s)	Ofev (nintedanib esylate) Jascayd (nerandomilast) pirfenidone (Esbriet)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years or older
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months.
Other Criteria Review/Revision Date: 2/2026	**Initial Authorization:** For All Requests: • Provider attests that they have reviewed member's other medications and have addressed all potential drug interactions • Documentation has been provided that the member does not smoke (Ofev and pirfenidone only) If the request is for Idiopathic Pulmonary Fibrosis (IPF): • Confirmed diagnosis of idiopathic pulmonary fibrosis • Pulmonary function tests indicate member has Forced Vital Capacity (FVC) greater than or equal to 45% within 30 days of request • If the request is for Jascavd or Ofev, the member has a documented trial and failure or intolerance with pirfenidone If the request is for Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): • The request is for Ofev (nintedanib) only • Confirmed diagnosis of SSc-ILD • FVC ≥ 40% within 30 days of request • Trial and failure of mycophenolate mofetil (MMF), cyclophosphamide, or azathioprine, or a medical reason was submitted as to why these therapies are not appropriate for the member. If the request is for Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a progressive phenotype: • The request is for Ofev (nintedanib) only • Diagnosis of chronic fibrosing ILD (such as connective tissue disease [CTD]-associated ILD, chronic fibrosing hypersensitivity pneumonitis [HP], idiopathic non-specific interstitial pneumonia [iNSIP], unclassifiable idiopathic interstitial pneumonia [IIP]) of a progressive phenotype • History of treatment in the last 12 months with at least one conventional medication used to treat ILD (e.g., corticosteroid, azathioprine, MMF, n-acetylcysteine (NAC), rituximab, cyclophosphamide, cyclosporine,

	tacrolimus), or a medical reason was submitted as to why these therapies are not appropriate for the member. • FVC ≥ 45% predicted within 30 days of request **<u>Reauthorization:</u>** • Documentation submitted indicates that the member has obtained clinical benefit from the medication • Documentation has been provided that the member does not smoke (Ofev and pirfenidone only) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Anti-Parkinson's Agents for OFF Episodes**
Drugs	Nourianz (istradefylline), Inbrija (levodopa) inhalation, apomorphine (Apokyn), Xadago (safinamide), Ongentys (opicapone), Vyalev (foscarbidopa and foslevodopa), Onapgo (apomorphine), or any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: The Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Inbrija or Vyalev: Concurrent use with a nonselective monoamine oxidase (MAO) inhibitor (such as phenelzine or tranylcypromine) • Onapgo and Apokyn: Concurrent use with 5HT3 antagonists, including antiemetics (e.g. ondansetron, granisetron, dolasetron, palonosetron) and alosetron; concurrent use with other apomorphine products • Concurrent use of Vyalev and Onapgo
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months and the reauthorization request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 8/2026
	<u>Initial Authorization:</u>
	• Diagnosis of Parkinson's disease
	• Patient is currently taking and will continue to take carbidopa/levodopa (does not apply to Vyalev)
	• Patient is experiencing symptom fluctuations or off episodes while taking carbidopa/levodopa where attempts have been made to adjust the carbidopa/levodopa dose and/or formulation in order to manage symptoms without success
	• Documented trial and failure (or contraindication) to **at least two** of the following adjunctive medication classes:
	  o COMT-inhibitors (e.g. entacapone)
	  o Dopamine agonists (e.g. ropinirole, pramipexole)
	  o MAO-B inhibitors (e.g. rasagiline, selegiline)
	• Dosing is appropriate as per labeling or is supported by compendia or standard of care guidelines
	• If the request is for Inbrija, patient does not have asthma, COPD, or other chronic underlying lung disease
	• If the request is for Onapgo, apomorphine (Apokyn), or any other newly marketed agent, patient must also have a documented trial and failure or intolerance to Apokyn
	• If the request is for Vyalev or Onapgo, prescriber attestation or documentation that the patient has advanced stage Parkinson's disease, and the patient is experiencing a minimum of 2.5 hours of "off" time per day

	• If the request is for Vyalev, member is taking ≥400 mg of levodopa per day **<u>Re-authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e., increase in "on" time without troublesome dyskinesia, decreased "off" time) • Dosing is appropriate as per labeling or is supported by compendia or standard of care guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Antipsychotic Drugs**
Drugs	**Preferred:** Abilify Maintena, Asimtufii (aripiprazole) aripiprazole oral solution aripiprazole tablet chlorpromazine tablet clozapine tablet clozapine ODT fluphenazine tablet fluphenazine decanoate injection haloperidol tablet haloperidol decanoate injection haloperidol lactate injection Invega Sustenna Invega Trinza Invega Hafyera lurasidone tablets lithium oral solution lithium capsule lithium ER tablet ziprasidone intramuscular inj. loxapine capsule olanzapine intramuscular injection olanzapine tablet Perseris injection (risperidone) perphenazine tablet perphenazine/amitriptyline pimozide tablet quetiapine tablet quetiapine ER tablet Risperdal Consta risperidone tablet risperidone oral solution risperidone ODT thioridizine tablet trifluoroperazine tablet thiothixene capsule ziprasidone capsule paliperidone tablet **Non-Preferred:** aripiprazole ODT Abilify tablet asenapine (Saphris) Abilify Mycite (aripiprazole) Aristada, Aristada Initio (aripiprazole lauroxil) Bysanti (milsaperidone) Caplyta (lumateperone) Clozaril (clozapine) Fanapt (iloperidone) Geodon (ziprasidone) Invega tablet Lybalvi (olanzapine and samidorphan) molindone tablet olanzapine ODT Erzofri Opipza film olanzapine-fluoxetine capsule Rexulti (brexpiprazole) Risperdal ODT, solution, tablet Rykindo injection (risperidone) Saphris Secuado (asenapine) Seroquel, Seroquel XR (quetiapine) Uzedy injection Versacloz (clozapine) Vraylar (cariprazine) Zyprexa, Zyprexa Zydis (olanzapine) Zyprexa Relprevv (olanzapine) risperidone microspheres ER inj any newly marketed product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request may be approved for 12 months.
Other Criteria	**<u>Criteria For Initial Approval:</u>** • Diagnosis appropriate per Covered Uses **AND**

Revision/Review Date: 11/2026	• For non-preferred drugs, prescriber documents that preferred formulary drugs have been tried or were considered **AND** it was determined that the drug prescribed will best treat the condition. **AND** • If the request is for a long-acting injectable antipsychotic, documentation that the member has tolerated and experienced a favorable response with oral dosage form **<u>Criteria for Continuation of Care (reauthorization and members on existing therapy including members new to the plan):</u>** • If the request is for a mental illness or emotional disturbance, documentation that the patient has been treated with the drug for at least 90 days prior to a change in SCHA's drug formulary or prior to becoming a SCHA member • Diagnosis appropriate per Covered Uses **NOTE: Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary**

Prior Authorization Group Description	**Antiviral Agents for Hepatitis B**	
Drugs	<u>Preferred:</u> entecavir tablet Baraclude oral solution lamivudine (Epivir HBV) tenofovir disoproxil fumarate (Viread)	<u>Non-preferred/Non-formulary:</u> adefovir Baraclude tablet Vemlidy (tenofovir alafenamide fumarate) Viread 40 mg/g oral powder any newly-approved agent for Hepatitis B
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.	
Exclusion Criteria	N/A	
Required Medical Information	See "other criteria"	
Age Restrictions	Age consistent with compendia data for the requested drug	
Prescriber Restrictions	Prescribed by (or working in consultation with) a gastroenterologist, hepatologist, or infectious disease specialist	
Coverage Duration	Initial Requests: If criteria are met, 6 months of therapy will be approved. Reauthorization requests: • For requests for patients undergoing chemotherapy: HBV prophylactic treatment is approved for 12 months upon completion of chemotherapy. • Reauthorization requests will not be considered for perinatal prophylaxis after 3 months postpartum; refer to other criteria categories to determine eligibility for continued treatment. • All other reauthorization requests will be approved for 12 months.	
Other Criteria	**<u>Initial criteria for all diagnoses in the adult population:</u>** • Diagnosis of hepatitis B • Medication is being prescribed at an appropriate FDA-approved dose (for age and weight) • For non-preferred drug requests, the member has had a trial of at least two preferred chemically unique drugs within the same drug class, or a trial of at least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class; or documentation was provided as to why the member cannot use preferred products • If the request is for an oral solution/oral powder, medical justification for use (i.e. difficulty swallowing) must be provided **For immune-active Chronic Hepatitis B:** • Laboratory values submitted are consistent with immune-active disease as outlined below: o HBV DNA > 2000 IU/ml	

	○ ALT > 66 U/L in males or > 50 U/L in females OR evidence of histological disease (significant inflammation and/or fibrosis) **For decompensated cirrhosis:** Presence of decompensated cirrhosis and detectable serum HBV DNA. **For compensated cirrhosis:** Presence of elevated HBV DNA ≥ 2000 IU/mL **Prophylaxis for Transplant Recipients with Hepatitis B:** ○ Patient is HBsAg-positive and undergoing liver transplantation, regardless of HBeAg status or HBV-DNA level pre-transplant; OR ○ Patient is HBsAg-negative and received a HBsAg-negative but anti-HBc–positive graft; OR ○ Patient has received a HBsAg-positive (non-liver) organ transplant. **Pregnant Women (for perinatal transmission prophylaxis only; patient does not meet other eligibility categories):** Patient is in the third trimester of pregnancy and is HBsAg-positive **Undergoing Chemotherapy or Will Be Initiating Cytotoxic Chemotherapy:** ○ Patient is HBsAg-positive, anti-HBc–positive regardless of baseline serum HBV DNA levels; OR ○ Patient is HBsAg-negative, anti-HBc–positive; AND 1) Receiving anti-CD20 antibody therapy (e.g., rituximab); OR 2) Undergoing stem cell transplantation.
	Immune-tolerant disease (normal ALT) Patient is an adult over 40 with elevated HBV DNA ≥ 1,000,000 IU/ml and liver biopsy showing significant necroinflammation or fibrosis **Acute Symptomatic Hepatitis B** • Patient has acute hepatitis B and one of the following: ○ Acute liver failure OR ○ Severe disease as indicated by one of the following: total bilirubin >3 mg/dL (or direct bilirubin >1.5 mg/dL), international normalized ratio (INR) >1.5, encephalopathy, or ascites **INITIAL CRITERIA for Treatment of Chronic Hepatitis B in children (<18 years of age):** • Diagnosis of hepatitis B • Medication is being prescribed at an appropriate FDA approved dose (for age and weight) ○ Patient is HBsAG-positive with ONE of the following:Evidence of significant fibrosis (≥F2) based on clinical criteria or an AST to Platelet Ratio Index (APRI) score of >0.5 or transient elastography value of >7 kPac or evidence of cirrhosis (F4) based on clinical criteria (or an APRI score of >1 or transient elastography value of >12.5 kPad), regardless of HBV DNA or ALT levels

Revision/Review Date: 8/2026	○ HBV DNA > 2000 IU/mL AND an ALT level above the ULN (30 U/L for boys and men and 19 U/L for girls and women) ○ Presence of coinfections (such as HIV, HDV and HCV), family history of liver cancer or cirrhosis, immune suppression (such as long-term steroids, solid organ or stem cell transplant), comorbidities (such as diabetes, metabolic dysfunction–associated steatotic liver disease and iron overload secondary to treatment for disorders of the blood) or extrahepatic manifestations (such as glomerulonephritis or vasculitis), regardless of APRI score or HBV DNA or ALT level ○ Persistently abnormal ALT levels (in the absence of access to an HBV DNA assay), regardless of APRI score • For non-preferred drug requests, the member has had a trial of at least two preferred chemically unique drugs within the same drug class, or a trial of at least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class; or documentation was provided as to why the member cannot use preferred products • If request is for oral solution/oral powder, medical justification for use (i.e. difficulty swallowing) must be provided. **<u>Reauthorization Criteria</u>** • Documented positive response to treatment as evidenced by decrease or normalization of ALT/AST and reduced HBVDNA levels **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Hepatitis D Treatment**
Drugs	Hepcludex (bulevirtide-gmod)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	"See Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, the request will be approved for 12 months.
Other Criteria Revision/Review Date 8/2026	**Initial Authorization** • Documentation of positive hepatitis D virus (HDV) antibody test or HDV ribonucleic acid (RNA) polymerase chain reaction (PCR) at least 6 months prior to start of treatment • Documentation of current positive HDV PCR result • Member's alanine transaminase level (ALT) is >1 but <10 x upper limit of normal (ULN) • Prescriber attests member has no history of decompensated liver disease • Prescriber attests member does not have uncontrolled HIV or active hepatitis C virus • Dosing is consistent with FDA-approved labeling **Reauthorization** • Documentation of positive clinical benefit (i.e., undetectable HDV RNA or decrease from baseline, ALT normalization, etc.) • Dosing is consistent with FDA-approved labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Aqvesme**
Drugs	Aqvesme (mitapivat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per package insert
Prescriber Restrictions	N/A
Coverage Duration	If all criteria are met, the initial request will be approved for up to 6 months and reauthorization will be approved for up to 12 months.

Other Criteria	**Initial Authorization:**
	• Documented diagnosis of one of the following forms of thalassemia confirmed by genetic testing:
	  o Beta thalassemia (with or without alpha-globin gene mutations)
	  o Hemoglobin E/beta thalassemia
	  o Alpha thalassemia/hemoglobin H disease
	• Documentation of one of the following:
	  o Hemoglobin ≤ 10 g/dL
	  o Member requires regular red blood cell (RBC) transfusions (defined as having had 6 to 20 RBC units transfused and no transfusion-free period of more than 6 weeks over the last 6 months)
	• Member does not have cirrhosis
	• Prescriber attests to measure liver laboratory tests (ALT, AST, ALP, and total bilirubin with fractionation) prior to initiation and during treatment
	• Member has not had prior exposure to gene therapy or prior bone marrow or stem cell transplantation
	• Medication is prescribed at an FDA approved dose
	
	Reauthorization:
	• Documentation of positive clinical benefit as evidenced by one of the following:
	  o Hemoglobin increase of at least 1 g/dL from baseline over a period of 12 weeks
	  o ≥50% reduction in transfused RBC units with a reduction of ≥ 2 units of transfused RBCs over a period of 12 weeks

Review/Revision Date: 05/2026	compared with baseline transfusion requirement • Member does not have cirrhosis or hepatocellular injury • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Arikayce (amikacin sulfate)**
Drug(s)	Arikayce (amikacin sulfate)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or infectious disease specialist
Coverage Duration	If all of the conditions are met, the request will be approved for 6 months.
Other Criteria Review/Revision Date: 5/2026	**Initial Authorization:** • Member has a diagnosis of *mycobacterium avium complex* (MAC) lung disease with a documented positive sputum culture • Member has failed guideline-based therapy with continued positive sputum cultures after 6 months or more of treatment • Member will continue to receive guideline-based treatment throughout use of Arikayce **Reauthorization:** • Member has documentation of one of the following: o Sputum conversion (three consecutive monthly negative sputum cultures) o Documentation indicating the member has experienced a clinical benefit as a result of therapy (e.g., improvement in six minute walk test (6MWT), improvement seen on imaging, improvement in respiratory symptom score) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**B-Cell Maturation Antigen (BCMA) Directed Chimeric Antigen Receptor (CAR) T-Cell Therapy**
Drugs	Abecma (idecabtagene vicleucel), Carvykti (ciltacabtagene autoleucel), any other marketed agent within the class
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by a hematologist, an oncologist, or other appropriate specialist
Coverage Duration	If all of the criteria are met, the initial request will be approved for a one – time infusion per lifetime.

Other Criteria
 	
Revision/Review Date: 05/2026
	<u>Initial Authorization</u>
	• Member has a diagnosis of relapsed or refractory multiple myeloma (RRMM)
	• For Abecma, member must have also received at least 2 prior lines of therapy, including:
	  o An immunomodulatory agent (e.g. lenalidomide, pomalidomide, thalidomide)
	  o A proteasome inhibitor (e.g. bortezomib, carfilzomib, ixazomib)
	  o An anti-CD38 monoclonal antibody (e.g. daratumumab, isatuximab)
	• For Carvykti, member must also be refractory to lenalidomide AND have received at least 1 prior line of therapy including:
	  o An immunomodulatory agent (e.g., lenalidomide, pomalidomide, thalidomide)
	  o A proteasome inhibitor (e.g., bortezomib, carfilzomib, ixazomib)
	• Member does not have an active infection or inflammatory disorder
	• Member will be screened for cytomegalovirus (CMV), hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines
	• Member will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment
	• Member has not previously received a BCMA CAR-T therapy
	
	<u>Re-authorization:</u>
	• Treatment exceeding 1 dose per lifetime will not be authorized.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Biologic Agents for Nasal Polyposis**
Drugs	**Preferred** Dupixent (dupilumab) Xolair (omalizumab) Nucala (mepolizumab) **Non-Preferred** Tezspire (tezepelumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Use of Dupixent, Xolair, and Nucala concomitantly or with another pulmonary biologic (e.g., Fasenra, Cinqair)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or otolaryngologist
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 11/2026	****Xolair:** For asthma, urticaria, and IgE-mediated food allergy, please refer to the "Xolair for Asthma, Urticaria, and IgE food allergy" policy** ****Dupixent:** For atopic dermatitis, please refer to the "Agents for Atopic Dermatitis" policy; For asthma and COPD, please refer to the "Pulmonary Biologics for Respiratory and Eosinophilic Conditions" policy** ****Nucala & Tezspire:** For asthma or other eosinophilic conditions, please refer to the "Pulmonary Biologics for Respiratory and Eosinophilic Conditions" policy** **Initial Authorization:** • Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) • Medication is being prescribed at an FDA approved dose • Patient is currently using an intranasal corticosteroid and will continue therapy, will be prescribed an intranasal corticosteroid with request, or has a medical reason for not using an intranasal corticosteroid • Documentation of ONE of the following: o Patient had prior surgery for nasal polyps OR o Trial and failure or intolerance, or a medical reason has been provided, for not using ALL of the following therapies: ▪ intranasal corticosteroids ▪ systemic corticosteroid • For requests for non-preferred drugs, a trial and failure of, or documented medical reason for not using a preferred drug is required **Re-authorization:** • Member will continue to use intranasal corticosteroid, or has a medical

	reason for not using an intranasal corticosteroid • Documentation has been provided that demonstrates a clinical benefit (e.g., improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS], nasal obstruction symptom visual analogue scale [VAS]) • Medication is being prescribed at an FDA-approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Bleeding Disorder Blood Products**
Drugs	**Preferred:** Advate, Adynovate, Afstyla, Alphanate, Alphanine SD, Alprolix, Benefix, Coagadex, Corifact, Eloctate, Esperoct, Feiba, Hemofil M, Humate-P, Idelvion, Ixinity, Jivi, Koate, Kogenate FS, Kovaltry, Novoeight, Novoseven RT, Nuwiq, Obizur, Profilnine SD, Rebinyn, Recombinate, Rixubis, Tretten, Vonvendi, Wilate, Xyntha, Xyntha Solofuse, Sevenfact **Non-Formulary/Non-preferred:** any newly marketed blood product indicated for a bleeding disorder
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be age appropriate per package insert
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	If all of the criteria are met, the request will be approved for 3 months.
Other Criteria Revision/Review Date: 11/2025	• Patient has a diagnosis of a bleeding disorder and the type of deficiency has been provided • The drug is being used for an FDA-approved indication at an FDA-approved dose or the indication/dose are otherwise supported by treatment guidelines • Requests for non-formulary/non-preferred products: Member has a documented treatment failure with at least two of the preferred agents OR has a documented medical reason (intolerance, hypersensitivity, contraindication, etc.) why they are not able to use preferred agents **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Botulinum Toxins A&B**
Drugs	abobotulinumtoxin A (Dysport) incobotulinumtoxin A (Xeomin) onabotulinumtoxin A (Botox) rimabotulinumtoxin B (Myobloc) DaxibotulinumtoxinA (Daxxify) or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	None
Coverage Duration	If all of the criteria are met, the request will be approved 12 months.
Other Criteria Revision/Review Date: 8/2026	****The use of these medications for cosmetic purposes is NOT a covered benefit under the Medical Assistance program.**** <u>Initial Criteria:</u> • The drug is being used for a medically accepted indication and dose as outlined in the Covered Uses section **Reauthorization Criteria:** • Documentation of provider attestation that demonstrates a clinical benefit • The requested drug is for a medically accepted dose as outlined in Covered Uses **Medical director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Brineura (cerliponase alfa)**
Drugs	Brineura (cerliponase alfa)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 8/2026
	<u>Initial Authorization:</u>
	• Documentation of confirmed diagnosis of neuronal ceroid lipofuscinosis type 2 (CLN2) with one of the following:
	  o Lab results demonstrating deficient TPP1 enzyme activity
	  o Identification of causative mutations in the TPP1/CLN2 gene
	• Documentation of baseline CLN2 Clinical Rating Scale motor + language score. Baseline CLN2 score must be > 0
	• Medication is prescribed at an FDA approved dose
	
	<u>Re-authorization:</u>
	• Documentation of CLN2 Clinical Rating Scale motor + language score has remained > 0
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Brinsupri (brensocatib)**
Drugs	Brinsupri (brensocatib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.
Other Criteria Review/Revision Date: 11/2025	**Initial Authorization:** • Diagnosis of bronchiectasis confirmed by chest CT scan • Documentation member does not have cystic fibrosis • At least 2 exacerbations in the past 12 months requiring an antibiotic prescription, urgent care or emergency room visit, or hospitalization • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. decrease in cough, sputum production, exacerbations, etc.) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Budesonide Nebulization Solution (Pulmicort Respules)**
Drugs	Preferred: budesonide inhalation suspension Non-preferred: BRAND Pulmicort Respules
Covered Uses	Medically accepted indications are defined using the following sources the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI),
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Budesonide suspension for nebulization will pay at point of sale for members < 11 years of age.
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 2/2026	For diagnosis of asthma in children 12 and older and adults: • Documentation as to why the member cannot use an inhaled corticosteroid via inhaler • Total daily dose should not exceed 2 mg. Doses beyond 2 mg/day should be reviewed for medical necessity. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Camzyos**
Drugs	Camzyos (mavacamten)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	≥ 18 years
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 8/2025
	<u>Initial Authorization:</u>
	• Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM)
	• Patient has a left ventricular ejection fraction (LVEF) ≥55%
	• Patient has a peak left ventricular outflow tract (LVOT) gradient ≥50 mmHg at rest or with provocation
	• Trial and failure or contraindication to ALL of the following:
	  o Beta blockers (i.e., metoprolol, propranolol, atenolol)
	  o Non-dihydropyridine calcium channel blockers (i.e., verapamil, diltiazem)
	• Prescriber attests that patient is not diagnosed with a disorder that causes cardiac hypertrophy that mimics oHCM (i.e., Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy)
	• Prescriber attests that patient is not using moderate to strong CYP2C19 inducers, strong CYP2C19 inhibitors, or moderate to strong CYP3A4 inducers
	• Medication is prescribed at an FDA approved dose
	
	<u>Re-Authorization:</u>
	• Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class
	• Patient has a left ventricular ejection fraction (LVEF) ≥50%
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Carisoprodol**
Drugs	carisoprodol (Soma) 250 mg, 350 mg tablets
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state-specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Member is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, requests for carisoprodol will be approved for a single fill for a maximum of 84 tablets for a 21 day supply with one refill per year.
Other Criteria	The member has tried and failed, or has a documented medical reason for not using, all of the following: • tizanidine • cyclobenzaprine • baclofen
Revision/Review Date: 08/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Chelating Agents**
Drugs	Preferred: deferasirox (Jadenu) tablets Chemet (succimer) capsules (pays at point of sale without PA) Non-preferred: deferasirox (Jadenu) oral granules, deferasirox (Exjade) tablets for oral suspension, deferiprone (Ferriprox) tablets, Ferriprox (deferiprone) solution, penicillamine capsules, radiogardase capsules, trientine capsules, Galzin (zinc acetate) capsules, Pentetate calcium trisodium, Pentetate zinc trisodium, Calcium Disodium Versenate (edetate calcium disodium), deferoxamine vial, Penicillamine tablet, Cuvrior tablet
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request will be approved for 6 months.
Other Criteria	**Requests for deferasirox (Exjade, Jadenu) only:** **Chronic iron overload due to blood transfusions:** • Member is 2 years of age or older • Diagnosis of chronic iron overload due to blood transfusions • Member is receiving blood transfusions on a regular basis/participating in blood transfusion program • Serum ferritin concentration is consistently > 1000 mcg/L. If the serum ferritin levels fall consistently below 500 mcg/L, deferasirox therapy must be discontinued • The medication requested is being prescribed at an FDA-approved dose • If the request is for deferasirox oral granules in packet, member has documented trial and failure of deferasirox tablets or medical reasons why deferasirox dispersible tablets cannot be used • If member is 21 years or older, documented trial and failure of parenteral deferoxamine (Desferal) or medical reason why parenteral deferoxamine cannot be used **Chronic iron overload in non-transfusion-dependent thalassemia syndromes:** • Member must be ≥ 10 years old • Diagnosis of thalassemia syndrome

Revision/Review Date: 8/2026	• Liver iron content (LIC) by liver biopsy of ≥ 5 mg Fe/g dry weight • Serum ferritin level > 300mcg/L on ≥ 2 measurements at least one month apart • The medication requested is being prescribed at an FDA-approved dose • If the request is not for deferasirox tablets, documentation was provided as to why the member cannot use deferasirox tablets whole or crushed **Requests for Ferriprox (deferiprone) only:** **Transfusional iron overload due to thalassemia syndrome, sickle cell disease, or other anemias:** • Member must be ≥ 3 years old for oral solution or ≥ 8 years old for tablets • Diagnosis of thalassemia, sickle cell disease, or other anemia • Member is receiving blood transfusions on a regular basis/participating in blood transfusion program • Serum Ferritin concentration is consistently > 1000 mcg/L. If the serum ferritin levels fall consistently below 500 mcg/L, Ferriprox must be discontinued • The medication requested is being prescribed at an FDA approved dose • Documentation patient is unable to use deferoxamine (Desferal) parenterally • Documented trial and failure of deferasirox (Exjade, Jadenu) or medical reason why deferasirox cannot be used **Requests for Wilson's Disease:** **Cuvrior (trientene tetrahydrochloride) only**: • Diagnosis of Wilson's disease • Patient is de-coppered • Patient is tolerant to penicillamine and will discontinue penicillamine before starting therapy with Cuvrior • The medication requested is being prescribed at an FDA approved dose **Trientene (Syprine) only:** • Diagnosis of Wilson's disease • Documented trial and failure, intolerance, or contraindication to penicillamine • The medication requested is being prescribed at an FDA approved dose **Requests for all other drugs and indications:** • The drug is requested for an appropriate use (per the references outlined in "Covered Uses") • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses")

	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Cystic Fibrosis transmembrane conductance regulator (CFTR) Modulators**
Drug(s)	Alyftrek (vanzacaftor/tezacaftor/deutivacaftor) Kalydeco, Kalydeco Granules (ivacaftor) Orkambi, Orkambi Granules (lumacaftor/ivacaftor) Symdeko (tezacaftor/ivacaftor) Trikafta (elexacaftor/tezacaftor/ivacaftor) any newly marketed CFTR modulator to treat cystic fibrosis
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	See "Other Criteria"
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescribed by a pulmonologist or specialist in the treatment of cystic fibrosis
Coverage Duration	If all of the criteria are met the initial request will be 6 months. Reauthorization requests will be 12 months.
Other Criteria Review/Revision Date 2/2026	<u>Initial authorization:</u> • Documentation provided includes a copy of the FDA-cleared cystic fibrosis (CF) mutation test OR documentation from the National Cystic Fibrosis Registry (e.g., screen shot) with member's genetic mutations • The request is for an FDA approved indication for the member's genotype and within dosing guidelines • The request is appropriate for member (e.g., age/weight) based on FDA-approved package labeling, peer reviewed medical literature, and nationally-recognized compendia. <u>Reauthorization criteria:</u> • Based on prescriber's assessment, member continues to benefit from therapy • The request is within FDA dosing guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention**
Drugs	Preferred • Emgality (galcanezumab-gnlm) • Ajovy (fremanezumab-vfrm) • Aimovig (erenumab-aooe) • Qulipta (atogepant) Non-preferred/Non-formulary • Vyepti (eptinezumab) • Nurtec ODT (if the request is for acute treatment of migraine please refer to the Acute Migraine Treatments criteria) • Any newly approved CGRP Antagonist for headache prevention
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Request for diagnosis of CHRONIC cluster headaches
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, migraine specialist, pain specialist, or other specialist in the treatment of headaches
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months

Other Criteria	**Initial Authorization**
	
	Migraine Headache Prophylaxis:
	• Diagnosis of episodic migraine (4 to 14 migraine days per month) or chronic migraine (≥ 15 headache days per month with ≥ 8 migraine days per month)
	• Documentation of the number of headache days per month should be provided with the request
	• Documented trial and failure (or a medical justification for not using e.g. hypersensitivity, baseline bradycardia or hypotension, adverse events experienced from previous trial, etc.) with at least one drug from **two categories** below for at least 4 weeks EACH, at minimum effective doses:
	  o Beta-adrenergic blocker
	  o Topiramate or divalproex/valproate/valproic acid
	  o Amitriptyline or venlafaxine
	  o For menstrual migraine prophylaxis only: frovatriptan, zolmitriptan or naratriptan
	• If the medication request is for a non-preferred CGRP receptor antagonist, the member has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure etc) for not using a preferred CGRP receptor antagonist
	• Requested dose is within FDA approved dosing guidelines
	
	Episodic Cluster Headache
	• Documented diagnosis of episodic cluster headache and requested medication is indicated for episodic cluster headache
	• Requested dose is within FDA approved dosing guidelines

Revision/Review Date: 11/2026	• Documented trial and failure of (or a medical justification for not using) verapamil for at least 4 weeks, at minimum effective dose **<u>Re-Authorization</u>** **Migraine Headache Prophylaxis:** • Reduction in number of headache days per month by ≥ 50% relative to pre-treatment baseline o Documentation of the number of headache days per month should be provided with the request **Episodic Cluster Headache** • Documented reduction in the frequency of headaches **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Cholbam**
Drugs	Cholbam (cholic acid)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is a gastroenterologist or hepatologist
Coverage Duration	If all of the conditions are met, the request will be approved for a 3 month duration for the first year of therapy, and then for a 6 month duration after one year of treatment.

Other Criteria
 	
Revision/Review Date: 11/2025
	<u>Initial authorization:</u>
	• Patient has a confirmed diagnosis of:
	  ○ Bile acid synthesis disorder due to single enzyme defect (SEDs)
	  OR
	  ○ Peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients that exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption
	• Current labs (within 30 days of request) have been submitted for the following:
	  ○ ALT/AST
	  ○ GGT (serum gamma glutamyltransferase)
	  ○ ALP (alkaline phosphatase)
	  ○ Bilirubin
	  ○ INR
	
	<u>Re-authorization:</u>
	• Documentation has been submitted indicating clinical benefit/liver function has improved since beginning treatment
	• For reauthorization after the first 3 months of treatment, lab results must show an improvement in liver function and there must be no evidence of biliary obstruction or cholestasis
	• Current labs (within 30 days of request) have been submitted for the following:
	  ○ ALT/AST
	  ○ GGT (serum gamma glutamyltransferase)
	  ○ ALP (alkaline phosphatase)
	  ○ Bilirubin
	  ○ INR
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents**
Drugs	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase) **If the request is for an immunoglobulin for CIDP, please refer to the Immune Globulins criteria**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a neurologist or neuromuscular specialist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 3 months. For reauthorization requests, the request will be approved for 12 months.
Other Criteria Review/Revision Date: 11/2025	**Initial Authorization:** • Diagnosis of CIDP confirmed by electrodiagnostic test results (e.g., electromyography or nerve conduction studies) • Patient has progressive or relapsing/remitting disease course for ≥2 months • Patient has an inadequate response, significant intolerance, or contraindication to intravenous immunoglobulin (IVIG) or subcutaneous immunoglobulin (SCIG) • Medication is prescribed at an FDA approved dose **Reauthorization:** • Documentation or provider attestation of significant clinical improvement in neurologic symptoms or stabilization of disease • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Continuous Glucose Monitors (CGMs)**
Products	Eversense Guardian Connect Enlite Any other newly-marketed CGM **Note: Dexcom G7, Dexcom G6, Freestyle Libre 2, Freestyle Libre 2 Plus sensor, Freestyle Libre 3 Plus Sensor, and Freestyle Libre 3 Reader, are preferred and will pay at POS without a prior authorization**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	See "Other Criteria"
Coverage Duration	If the conditions are met, the request will be approved for the following: • one meter and one reader (as applicable) for 12 months • up to 5 sensors per 30 days may be approved for 12 months • one (1) Eversense transmitter for 12 months • one (1) Guardian Connect transmitter for 12 months

Other Criteria
 	
Revision/Review Date: 8/2026
	• Diagnosis of diabetes
	• One of the following:
	  o Member is using insulin
	  o Recent (past 6 months) history of problematic hypoglycemia (e.g. frequent or severe hypoglycemia, nocturnal hypoglycemia, hypoglycemia unawareness)
	  o Continuation of therapy with existing CGM
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Complement Inhibitors**
Drugs	Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan), Syfovre (pegcetacoplan injection), Izervay (avacincaptad pegol injection), Fabhalta (iptacopan), Voydeya (danicopan), PiaSky (crovalimab-akkz), BKEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a hematologist, nephrologist, neurologist, oncologist, ophthalmologist, or other appropriate specialist.
Coverage Duration	If the criteria are met, the criteria will be approved as follows: Initial requests: • 3 months: eculizumab (Soliris, BKEMV, Epysqli), Ultomiris (ravulizumab), Voydeya (danicopan) • 6 months: Fabhalta (iptacopan), PiaSky (crovalimab-akkz), Empaveli (pegcetacoplan) • 12 months: Syfovre (pegcetacoplan), Izervay (avacincaptad pegol) Reauthorization: • 6 months: eculizumab (Soliris, BKEMV, Epysqli), Ultomiris (ravulizumab), Empaveli (pegcetacoplan), Voydeya (danicopan) • 12 months: Syfovre (pegcetacoplan), Fabhalta (iptacopan), PiaSky (crovalimab-akkz), Izervay (avacincaptad pegol)
Other Criteria	**<u>Initial Authorization:</u>** • The request is for a dose that is FDA approved or in nationally recognized compendia in accordance with the patient's diagnosis, age, body weight, and concomitant medical conditions; **AND** • For eculizumab (Soliris, BKEMV, Epysqli), Ultomiris (ravulizumab), Empaveli (pegcetacoplan), Fabhalta (iptacopan), PiaSky (crovalimab-akkz) and Voydeya (danicopan) o Documentation patient complies with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria. • For Soliris or BKEMV, patient must have a documented trial and failure or intolerance to Epysqli or a medical reason why Epysqli cannot be used. **Paroxysmal Nocturnal Hemoglobinuria (PNH):** • Documentation of diagnosis by high sensitivity flow cytometry • Presence of 1 or more of the following PNH-related signs or symptoms: o fatigue, hemoglobinuria, abdominal pain, shortness of breath (dyspnea), anemia, history of a major adverse vascular event

Revision/Review Date 8/2026	(including thrombosis), dysphagia, erectile dysfunction, or history of pRBC transfusion due to PNH. • Adults: For Ultomiris (ravulizumab), Empaveli (pegcetacoplan), Fabhalta (iptacopan), or PiaSky (crovalimab-akkz) patient must have a documented trial and failure or intolerance to Epysqli or a medical reason why Epysqli cannot be used. • For Voydeya (danicopan): o Member has been receiving eculizumab (Soliris, BKEMV, Epysqli), or Ultomiris (ravulizumab) therapy for at least 6 months o Member has clinically evident extravascular hemolysis [defined as anemia (Hgb ≤9.5 gram/deciliter) with absolute reticulocyte count ≥120 x 10^9/liter] despite treatment with eculizumab (Soliris, BKEMV, Epysqli) or Ultomiris (ravulizumab) o Voydeya (danicopan) will be used as add-on therapy to eculizumab (Soliris, BKEMV, Epysqli) or Ultomiris (ravulizumab) **Generalized Myasthenia Gravis (gMG):** • Refer to the "Myasthenia Gravis Agents" policy **Neuromyelitis Optica Spectrum Disorder (NMOSD)** • Refer to the "Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents" policy **IgA Nephropathy:** • Refer to the "IgA Nephropathy Agents" policy **Atypical Hemolytic Uremic Syndrome (aHUS)/Complement-Mediated HUS):** • Documentation of confirmed diagnosis as evidenced by complement genotyping and complement antibodies; **OR** • Provider attestation treatment is being used empirically and delay in therapy will lead to unacceptable risk to the patient **Geographic Atrophy (GA):** • If the request is for Syfovre (pegcetacoplan injection), member must be ≥ 60 years of age • If the request is for Izervay (avacincaptad pegol injection), member must be ≥ 50 years of age • Diagnosis of GA secondary to age-related macular degeneration (AMD) • Absence of choroidal neovascularization (CNV) in treated eye • Best-corrected visual acuity (BCVA) of 24 letters (approximately 20/320) or better using Early Treatment Diabetic Retinopathy Study (ETDRS) • GA lesion size ≥ 2.5 and ≤ 17.5 mm^2 with at least 1 lesion ≥ 1.25 mm^2

	Complement 3 Glomerulopathy (C3G) and Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN): • Diagnosis of primary C3G or IC-MPGN as confirmed by renal biopsy • Patient's urine protein to creatinine ratio (UPCR) is ≥ 1.0 g/g • Patient has an eGFR ≥ 30 mL/min/1.73 m^2 • Patient has been taking maximally recommended or tolerated dose of an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for at least 90 days, or a medical reason is provided why this is inappropriate • For Fabhalta: Patient does not have recurrent C3G post kidney transplant **<u>Re-Authorization:</u>** • Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality of life scores, increase in Hgb, reduced need for blood transfusions, slowing of growth rate of GA lesions, improvement in UPCR, etc.); **AND** • The request is for a dose that is FDA approved or in nationally recognized compendia in accordance with the patient's diagnosis, age, body weight, and concomitant medical condition; **AND** • If the request is for aHUS/Complement Mediated HUS o Documentation of confirmed diagnosis as evidenced by complement genotyping and complement antibodies **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Cobenfy (xanomeline and trospium chloride)**
Drugs	Cobenfy (xanomeline and trospium chloride)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with a psychiatrist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Review Date: 02/2026
	<u>Initial Authorization:</u>
	• Diagnosis of schizophrenia, consistent with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria.
	• Documented trial and failure with two alternative formulary/preferred antipsychotic agents, or a medical reason is provided for not using any typical or atypical antipsychotic agents.
	• Medication is prescribed at an FDA approved dose.
	• Provider attestation is provided that the member does not have any of the following:
	  o Moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment
	  o Untreated Narrow-Angle Glaucoma
	  o Urinary Retention
	  o Gastric Retention
	
	<u>Re-Authorization:</u>
	• Documentation or provider attestation of positive clinical response (i.e. improvement in positive and/or negative symptoms of schizophrenia)
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Ivabradine (Corlanor)**
Drugs	Ivabradine (Corlanor)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months and reauthorization requests will be approved for up to 12 months.
Other Criteria Revision/Review Date: 02/2026	**Heart Failure in Adult Patients:** 1. Member is aged 18 years or older 2. Member has a diagnosis of stable symptomatic chronic heart failure (NYHA functional class II-IV) with a left ventricular ejection fraction ≤ 35% 3. Member is in sinus rhythm with a resting heart rate ≥ 70 beats per minute (bpm) 4. Member is currently being prescribed, or documentation has been provided that the member is not able to tolerate, an evidence based beta-blocker (i.e., bisoprolol, carvedilol, metoprolol succinate) at maximally tolerated dose 5. The medication is being prescribed at an FDA approved dosage **Heart Failure in Pediatric Patients:** 1. Member is aged 6 months to less than 18 years of age 2. Member has stable heart failure (NYHA/Ross functional class II-IV) due to dilated cardiomyopathy and a left ventricular ejection fraction ≤ 45% 3. Member is in sinus rhythm with an elevated resting heart rate 4. The medication is being prescribed at an FDA approved dosage **Reauthorization** 1. Dose consistent with package insert or guidelines/compendia 2. Attestation that patient has experienced clinical benefit **Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Corticosteroids for Duchenne Muscular Dystrophy (DMD)**
Drugs	deflazacort (Emflaza) Agamree (vamorolone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist in Duchenne Muscular Dystrophy (DMD)
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 02/2026	**Initial Authorization:** • Confirmed diagnosis of Duchenne Muscular Dystrophy (such as documented mutation of dystrophin gene, genetic sequencing indicating mutations attributed to Duchenne Muscular Dystrophy, muscle biopsy indicating absence of dystrophin protein, etc.), and copies of testing were submitted with request • Trial and failure with prednisone, and documented medical reason why prednisone cannot be continued • The request is for an FDA approved dose **Reauthorization:** • Documentation or attestation of clinical benefit (such as improved muscle strength, muscle function, or overall symptom improvement) • The request is for an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Corticotropin**
Drugs	Acthar (corticotropin) Cortrophin (corticotropin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	See "Other Criteria"
Coverage Duration	If all the criteria are met, the request will be approved for up to a 1 month duration.
Other Criteria Revision/Review Date: 5/2026	**<u>Infantile Spasms (West Syndrome):</u>** • Patient is < 2 years of age • The medication is being prescribed by a neurologist. • Documentation of the patient's current weight (in kg) and height/length (in cm) or body surface area (BSA) **<u>Multiple Sclerosis:</u>** • Documentation was submitted that patient is having acute attack, with neurologic symptoms and increased disability or impairments in vision, strength or cerebellar function, and has failed therapy with intravenous (IV) methylprednisolone, or a medical reason has been submitted why patient is unable to use IV methylprednisolone. • The medication is being prescribed by a neurologist • If the request is for Acthar, trial and failure of, contraindication to, or medical reason for not using Cortrophin. **<u>All Other FDA Approved Conditions and Indications:</u>** • Documented trial and failure of parenteral AND enteral corticosteroids, or documented medical reason for why the patient cannot use these therapies for treatment **AND** • Documentation was provided that ALL other standard therapies have been used to treat the member's condition as described in medical compendia (Micromedex, AHFS, Drug Points, and package insert) as defined in the Social Security Act and/or per recognized standard of care guidelines OR there is a documented medical reason (i.e. medical intolerance, treatment failure, etc.) for why all other standard therapies could not be used to treat the member's condition. **AND** • Prescriber is a specialist in the condition they are treating. • If the request is for Acthar, trial and failure of, contraindication to, or medical reason for not using Cortrophin. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Crenessity**
Drugs	Crenessity (crinecerfont)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Members with non-classic congenital adrenal hyperplasia (CAH) • Members with adrenal insufficiency due to causes other than 21-hydroxylase deficiency
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or other specialist experienced in managing congenital adrenal hyperplasia
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Medically confirmed diagnosis of classic 21-hydroxylase deficiency congenital adrenal hyperplasia (CAH) • Member is currently on stable regimen of glucocorticoid therapy and will continue to use glucocorticoids in combination with Crenessity • Medication is prescribed at an FDA approved dose according to package insert • Member's current weight • For adults and pediatric members weighing ≥55 kg, or members weighing ≥20 kg if CYP3A4 dose adjustment is required: capsule formulation is requested OR documentation is provided that member is unable to swallow capsule whole • Dosing requests for capsule formulations will employ strategies to minimize the total number of capsules used daily (i.e., "doubling up" on lower strength capsules to achieve a higher dose when the requested dose strength exists will not be authorized) **Re-Authorization:** • Documentation is provided that member has successfully achieved a reduction in glucocorticoid dosage from baseline. • Medication is prescribed at an FDA approved dose according to package insert • Member's current weight • For all adults and pediatric members weighing ≥55 kg or members weighing ≥20 kg if CYP3A4 dose adjustment is

Review/Revision Date: 05/2026	required: capsule formulation is requested OR documentation is provided that member is unable to swallow capsule whole • Dosing requests for capsule formulations will employ strategies to minimize the total number of capsules used daily (i.e. "doubling up" on lower strength capsules to achieve a higher dose when the requested dose strength exists will not be authorized) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Crinone**
Drugs	Crinone (micronized progesterone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Treatment of infertility
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met for prevention of spontaneous preterm delivery, the request will be approved for 30 single use applicators per 30 days until the end of pregnancy. If the criteria are met for secondary amenorrhea, the request will be approved for 6 doses.
Other Criteria Revision/Review Date: 8/2026	**<u>Criteria for Authorization:</u>** • **Requests for prevention of spontaneous preterm delivery**: o Member has singleton pregnancy and prior preterm birth or short cervix • **Requests for secondary amenorrhea** o Documented diagnosis of secondary amenorrhea AND o Member has tried and failed or has a documented allergy/ contraindication/intolerance to oral progestin therapy (e.g. micronized progesterone capsules, medroxyprogesterone acetate tablets, norethindrone tablets) o If the request is for Crinone 8% gel, documentation is required that the member has tried and failed Crinone 4% gel. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Ctexli (chenodiol)**
Drugs	Ctexli (chenodiol)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Concurrent use with Chobalm (cholic acid)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, endocrinologist, or specialist in metabolic disorders.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Medication is prescribed at an FDA approved dose • Diagnosis of cerebrotendinous xanthomatosis (CTX) confirmed by genetic testing that detects variants in the CYP27A1 gene (copies of test must be submitted with request) **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. stabilization of cognitive development, improvement in laboratory abnormalities [i.e. urine 23S-pentol and plasma cholestanol], etc.) • Medication is prescribed at an FDA approved dose
Review/Revision Date: 05/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Dalfampridine**
Drugs	dalfampridine (Ampyra)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), or the Drug Package Insert (PPI).
Exclusion Criteria	• History of seizures • Moderate or severe renal impairment (creatinine clearance $\leq$ 50 mL/minute)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a neurologist or other specialist in the treatment of multiple sclerosis
Coverage Duration	If all the criteria are met, the initial request will be approved for 6 months. Reauthorization requests will be approved for 12 months.
Other Criteria Revision/Review Date: 02/2026	**Initial Authorization:** • Member has a diagnosis of multiple sclerosis (MS) • Member is ambulatory AND has a walking impairment. • Documentation of baseline objective measure of walking ability (e.g., 25 foot walk test, 6 minute walk distance, Multiple Sclerosis Walking Scale (MSWS-12)) must be submitted with the request. • Documentation of baseline creatinine clearance (within 60 days of request) above 50 mL/min • Documentation was submitted (consistent with pharmacy claims data or for new members to the health plan, consistent with chart notes) that member is currently receiving disease-modifying therapy for MS or documentation of a medical reason (intolerance, hypersensitivity) as to why the member is unable to use MS disease-modifying therapy • Drug is being requested at an FDA-approved dose **Re-authorization:** • Documentation of improvement in objective measure of walking ability from baseline was submitted with request • Member is receiving disease-modifying therapy for MS or documentation of a medical reason (intolerance, hypersensitivity) for not using MS disease-modifying therapy has been submitted • Drug is being requested at an FDA-approved dose

Prior Authorization Group Description	**Danazol**
Drugs	danazol capsules
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Pregnancy
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	See "other criteria"
Coverage Duration	If the criteria are met, the request will be approved with for 6 months.
Other Criteria Revision/Review Date: 2/2026	**ENDOMETRIOSIS** • Diagnosis of endometriosis • Documentation of one of the following: o Trial and failure of (or documented medical reason for not using) first line therapy of combined estrogen/progestin or progestin-only contraceptive therapy in combination with an NSAID. o Trial and failure of gonadotropin-releasing hormone (GnRH) agonists or GnRH antagonists (e.g. Orilissa [elagolix] or Myfembree (relugolix, estradiol, and norethindrone acetate)). • Prescriber must be a gynecologist **HEREDITARY ANGIOEDEMA:** • Diagnosis of hereditary angioedema • Prescriber must be an immunologist, allergist, rheumatologist, or hematologist **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Daybue (trofinetide)
Drugs	Daybue (trofinetide) oral solution Daybue Stix (trofinetide) oral packet
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or geneticist
Coverage Duration	If all the criteria are met, the initial request will be approved for 3 months. For reauthorization, the request will be approved for 6 months.

Other Criteria
 	
Revision/Review Date 8/2026
	Initial Authorization:
	• Medication is prescribed at an FDA approved dose
	• Diagnosis of classic or typical Rett Syndrome (RTT)
	• Documentation or attestation of mutation of the MECP2 gene
	• Documentation of patient weight
	• Documentation or provider attestation of all the following:
	  o Clinical Global Impression–Severity (CGI-S) score of ≥4
	  o Baseline Rett Syndrome Behavior Questionnaire (RSBQ) score
	
	Re-Authorization:
	• Documentation or provider attestation of positive clinical response (i.e., decrease from baseline in RSBQ score, decrease in Clinical Global Impression–Improvement (CGI-I, etc.)
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Diabetic Testing Supplies**
Products	**Preferred Glucose Monitors:** Accu-Chek Guide Accu-Chek Guide Me Contour Contour Next EZ Contour Next ONE **Preferred Test Strips:** Accu-Chek Aviva Plus Accu-Chek Guide Accu-Chek Smartview Contour Contour Next *Preferred products pay at POS within quantity limits without prior authorization*
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If criteria are met, requests will be approved for 12 months. A maximum of 102 test strips per month will be approved (depending on package size). A maximum of one meter per year will be approved.
Other Criteria	Criteria for approval of **Non-Preferred** products: • Member is legally blind or has reduced visual acuity so that they are unable to see the numbers on ALL of the preferred products and the requested product has a feature that enables the member to use the meter that is not available on any of the preferred meters. The member (not a caregiver) must be the one using the monitor/strips OR • Member is currently using an insulin pump that needs specific meter compatibility to accurately dose insulin OR • Preferred meter is not compatible with insulin pump member is using OR • Member is unable to change to a preferred meter and strip combination due to a cognitive or developmental disability OR • Changing to a preferred meter and strip combination would create undue hardship for the member Criteria for approval over the **Quantity Limit for Test Strips**: • The member has been stabilized on the current regimen. Stabilization on the current regimen is defined as having the prescription filled at least two times in the past 90 days AND the plan has paid for the previous two fills in excess of the quantity limit. OR • The member has a diagnosis of type 1 diabetes AND approved quantity will not exceed 306 strips per 30 days OR • The member has a diagnosis of type 2 diabetes AND

Revision/Review Date: 5/2026	• The member needs to test more than 3 times per day due to one of the following:
	  o The member has not been prescribed test strips previously OR
	  o The member's diabetes medication regimen (including insulin) is undergoing changes AND
	• Approved quantity will not exceed 204 strips per 30 days
	
	Quantity limit overrides are not available for glucose monitors, continuous glucose monitors, transmitters, or sensors
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Dificid (fidaxomicin)**
Drugs	Dificid (fidaxomicin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), or the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA labeling
Prescriber Restrictions	Prescriber must be a specialist in infectious disease, or working in consultation with an infectious disease specialist or gastroenterologist
Coverage Duration	For First Occurrence of CDI: If all of the criteria are met, the request may be approved for up to 10 days. For First Recurrent CDI: If the criteria are met, the request will be approved for up to a 25-day duration.
Other Criteria Revision/Review Date: 2/2026	• Diagnosis of *Clostridium* (or *Clostridioides*) *difficile* infection (CDI) • If this is the first occurrence or the FIRST recurrent episode of CDI, documentation of treatment failure with oral vancomycin is required, or medical reason why patient is unable to use oral vancomycin • Dose requested follows FDA labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Dojolvi**
Drugs	Dojolvi (triheptanoin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is a specialist in the treatment of the indicated condition
Coverage Duration	Initial: 6 months Renewal: 12 months

Other Criteria
 	
Revision/ Review Date: 11/2025
	<u>Initial Authorization</u>:
	• Member has a molecularly confirmed diagnosis of a long-chain fatty acid oxidation disorder (LC-FAOD)
	• Documentation of at least two of the following:
	  o Disease specific elevation of acylcarnitines on a newborn blood spot or in plasma
	  o Low enzyme activity in cultured fibroblasts
	  o One or more known pathogenic mutations in either the *CPT2, ACADVL, HADHA, or HADHB* gene
	• Member will not be receiving any other medium-chain triglyceride products while taking Dojolvi
	• Documentation of member's daily caloric intake (DCI)
	• Dose is within FDA-indicated limits and does not exceed 35% of DCI
	
	<u>Re-Authorization:</u>
	• Documentation submitted indicating the member has experienced a clinical benefit (e.g. increased left ventricular ejection fraction, reduced left ventricular wall mass, reduced maximum heart rate, decreased incidence of rhabdomyolysis)
	• Documentation of member's DCI
	• Dose is within FDA-indicated limits and does not exceed 35% of DCI
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Durysta (bimatoprost) intracameral implant
Drugs	Durysta (bimatoprost) intracameral implant
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Any of the following conditions: • Active or suspected ocular or periocular infection • Corneal endothelial cell dystrophy (e.g., Fuchs' Dystrophy) • Prior corneal transplantation, or endothelial cell transplants [e.g., Descemet's Stripping Automated Endothelial Keratoplasty (DSAEK)] • Patients whose posterior lens capsule is absent or ruptured
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be ≥ 18 years of age
Prescriber Restrictions	Must be prescribed by, or in consultation with, an ophthalmologist
Coverage Duration	If all of the criteria are met, the request will be approved for one implant per affected eye. Requests for repeat administration into an eye which has previously received a Durysta implant will not be approved.
Other Criteria Date: 11/2025	**Initial Authorization:** • Durysta is prescribed for a diagnosis of open angle glaucoma or ocular hypertension • Documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a topical eye drop for treatment (ex. prostaglandin analogs, beta-blockers, alpha agonists, etc.) **Re-Authorization:** • Requests for repeat administration into an eye which has previously received a Durysta implant will not be approved. **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Prior Authorization Group Description	**Duvyzat (givinostat)**
Drugs	Duvyzat (givinostat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a neurologist or provider who specializes in the treatment of Duchenne Muscular Dystrophy (DMD)
Coverage Duration	If all the criteria are met, the request will be approved for 12 months.
Other Criteria Review/Revision Date: 8/2026	**<u>Initial Authorization:</u>** • Medication is prescribed at an FDA approved dose according to body weight • Genetically confirmed diagnosis of DMD and copies of testing were submitted with request • Patient has been stable on baseline corticosteroids for at least 6 months • Patient is ambulatory • Member's platelet count is ≥ 150 x 109/L **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (such as improved muscle function, muscle strength, or disease stabilization) • Patient is on concurrent corticosteroid treatment • Patient is ambulatory • Medication is prescribed at an FDA approved dose according to body weight **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Elevidys (delandistrogene moxeparvovec)**
Drugs	Elevidys (delandistrogene moxeparvovec)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Any deletion in exon 8 and/or exon 9 in the Duchenne muscular dystrophy (DMD) gene • Concurrent use with an exon skipping drug, such as Exondys 51, Amondys 45, Vyondys 53, Viltepso
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by neurologist or provider who specializes in the treatment of DMD
Coverage Duration	If all of the criteria are met, the request will be approved for a **one-time treatment.**
Other Criteria Review/Revision Date: 08/2026	• Medication is prescribed at an FDA approved dose • Documentation of weight • Genetically confirmed diagnosis of DMD and copies of testing were submitted with request • Attestation patient is ambulatory • Attestation member has anti-recombinant adeno-associated virus serotype rh74 (anti-AAVrh74) total binding antibody titers of less than 1:400 • Attestation prescriber has assessed the safety and monitoring requirements in the labeling and determined the patient is an appropriate candidate for Elevidys, including: o liver function o platelet counts and troponin-I levels o current or recent infections o recent vaccinations **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Elmiron**
Drugs	Elmiron (pentosan polysulfate sodium)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	16 years and older
Prescriber Restrictions	Prescribed by a urologist, obstetrician/gynecologist, or other specialist in the treatment of genitourinary disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for up to 6 months, and the reauthorization request will be approved for up to 12 months.

Other Criteria	<u>Initial Authorization</u>
	Documentation of all of the following is required:
	• Diagnosis of bladder pain or discomfort associated with interstitial cystitis
	• The member has tried and failed all of the following:
	  o Self-care practices and behavior modification (e.g., fluid management, bladder training, avoidance of activities/food/ beverages that exacerbate symptoms)
	  o Amitriptyline (or a documented medical reason why amitriptyline is not appropriate for the member, e.g., age over 65)
	• Documentation of baseline Genitourinary Pain Index (GUPI) and urinary frequency or urgency
	• Requested dose is within FDA approved guidelines
	
	<u>Reauthorization</u>
	• Documentation is provided that the member has obtained a clinical benefit (e.g., reduction in GUPI, reduced pelvic or bladder pain, reduced urinary frequency or urgency)
	• Requested dose is within FDA approved guidelines

Revision/Review Date: 11/2025	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Emergency Use Authorization (EUA) Drugs/Products for COVID-19**
Drugs	Any drug/product approved by EUA for COVID-19
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Emergency Use Authorization for the drug/product in question, and the Drug Package Insert (PPI).
Exclusion Criteria	See "Other Criteria"
Required Medical Information	See "Other Criteria"
Age Restrictions	As outlined within current FDA Emergency Use Authorization (EUA) guidelines
Prescriber Restrictions	N/A
Coverage Duration	As outlined within current FDA Emergency Use Authorization (EUA) guidelines
Other Criteria	Emergency Use Authorization for COVID-19 related drugs/products (all must apply): • The requested drug/product has a currently active Emergency Use Authorization as issued by the U.S. Food and Drug Administration. • Use of the requested drug/product is consistent with the current terms and conditions of the emergency use authorization (such as appropriate age/weight, formulation, disease severity, concurrent use with other medications or medical interventions, etc.). • Attestation that the provider is not requesting reimbursement for ingredient cost of drug when drug is provided by U.S. government or through a patient assistance program at no charge
Revision/Review Date: 02/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Encelto**
Drugs	Encelto (revakinagene taroretcel-lwey)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by an ophthalmologist or specialist in the treatment of macular telangiectasia (MacTel) type 2
Coverage Duration	If all of the criteria are met, the request will be approved for a single implant per eye per lifetime.
Other Criteria Revision/Review Date: 05/2026	**<u>Initial Authorization</u>** • Confirmed diagnosis of idiopathic MacTel type 2 • Inner segment (IS)/outer segment (OS) photoreceptor (PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00 mm^2 measured by spectral domain-optical coherence tomography (SD-OCT) • Best corrected visual acuity (BCVA) score of 54 letters or better (20/80 or better Snellen equivalent) measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart • Prescriber attests that member has no evidence of neovascular MacTel type 2 • Member has not previously received an Encelto implant for treated eye *****Reauthorizations are not permitted, as members are limited to a single implant per eye per lifetime.***** **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Endari (L-Glutamine)
Drugs	**Preferred** Endari **Non-Preferred** L-Glutamine
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a hematologist or sickle cell specialist
Coverage Duration	If all of the criteria are met, requests will be approved for 12 months.
Other Criteria Revision/Review Date 2/2026	Initial approval: • Member has diagnosis of sickle cell disease • Documentation was provided that the patient had 2 or more crises in the last 12 months • Documentation was provided the member has been on hydroxyurea at the maximum tolerated dose and was compliant within the last 6 months (or a medical reason was provided why patient is unable to use hydroxyurea) • Request is for an FDA approved dose • For requests for non-preferred drugs, a trial and failure of, or documented medical reason for not using a preferred drug is required Reauthorization: • Prescriber attests member had reduction in number of sickle cell crises • Request is for an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Enzyme Replacement Therapies for Fabry Disease**
Drugs	Fabrazyme (agalsidase beta) Elfabrio (peguniigalsidase alfa)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to the package insert
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, cardiologist, nephrologist or specialist experienced in the treatment of Fabry disease
Coverage Duration	Initial Authorization: If all the criteria are met, the request will be approved for a 6-month duration. Reauthorization: If all the criteria are met, the request will be approved for a 12-month duration.
Other Criteria Revision/Review Date: 08/2026	**<u>Initial Authorization</u>:** • Male members must have a documented diagnosis of Fabry disease confirmed by ONE of the following: 1. An undetectable (<1%) alpha galactosidase A (alpha-Gal-A) activity level 2. A deficient alpha-Gal- activity level AND a documented detection of pathogenic mutations in the galactosidase alpha (*GLA*) gene by molecular genetic testing • Female members must have a documented diagnosis of Fabry disease confirmed by detection of pathogenic mutations in the *GLA* gene by molecular genetic testing AND evidence of clinical manifestation of the disease (e.g., kidney, neurologic, cardiovascular, gastrointestinal) • Member must not be using concurrently with Galafold (migalastat) • Documentation of the member's current weight • Request is for an FDA-approved dose **<u>Re-Authorization:</u>** • Documentation that member has experienced an improvement in symptoms from baseline including but not limited to: decreased pain, decreased gastrointestinal manifestations, decrease in proteinuria, stabilization of increase in eGFR, reduction of left ventricular hypertrophy (LVH) on echocardiogram, or improved myocardial function, or has remained asymptomatic • Member must not be using concurrently with Galafold (migalastat) • Documentation of the member's current weight • Request is for an FDA-approved dose **Physician/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Eohilia**
Drugs	Eohilia (budesonide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, allergist, immunologist, or other provider who specializes in the treatment of eosinophilic esophagitis (EoE)
Coverage Duration	If all criteria are met, the request will be approved for 3 months ***Reauthorization requests for maintenance therapy will not be approved as Eohilia has not been shown to be safe and effective for the treatment of EoE for longer than 12 weeks. Requests for subsequent courses for induction therapy will be handled on a case-by-case basis***
Other Criteria Revision/Review Date: 5/2026	• Diagnosis of EoE as confirmed by esophageal biopsy indicating ≥15 eosinophils per high-power field (eos/hpf) • Member must have experienced dysphagia for at least 4 days over a 2-week period • Documented trial and failure, intolerance, or contraindication to one proton pump inhibitor (PPI) at a maximally tolerated dose for a minimum of 8 weeks • Documented trial and failure, intolerance, or contraindication to an inhaled corticosteroid that can be swallowed (i.e., fluticasone propionate) • Request is for an FDA-approved dose **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Epidermolysis Bullosa Agents**
Drugs	Filsuvez (birch triterpenes) Vyjuvek (beremagene geperpavec-svdt)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Other forms of epidermolysis bullosa, such as epidermolysis bullosa simplex, junctional epidermolysis bullosa, kindler epidermolysis bullosa • Concurrent use of Vyjuvek,Filzuvez or Zevaskyn • Receipt of any prior chemical or biologic product for the treatment of epidermolysis bullosa, including Zevaskyn, Vyjuvek and Filsuvez, to the requested treatment area
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a dermatologist, geneticist, or specialist experienced in the treatment of epidermolysis bullosa.
Coverage Duration	If all of the criteria are met, the initial request will be approved for three (3) months. Reauthorization requests will be approved for six (6) months.
Other Criteria Review/Revision Date: 5/2026	**<u>Initial Authorization:</u>** • Member has a diagnosis of dystrophic or junctional epidermolysis bullosa, with genetic mutation(s) confirmed via genetic testing. • Requested product is FDA approved for the patient's epidermolysis bullosa subtype • Documentation is provided that wound(s) to be treated are clean with adequate granulation tissue, excellent vascularization, and do not appear infected • Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated • Medication is prescribed at an FDA approved dose, and maximum dispensable amount is not exceeded o Vyjuvek: Requests exceeding more than one vial per week will not be approved. o Filsuvez: Documentation of size of treatment area(s) and frequency of dressing changes is required. One tube of Filsuvez covers up to 250 cm^2 surface area per single use tube. Requests exceeding use more than once daily will not be approved. Rounding to the next whole tube size necessary is allowed. **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e., improvement in wound appearance, wound closure, healing, etc.) • Documentation indicating need for continued treatment is needed (either to partially healed wounds or to other wound sites) • Documentation is provided that wound(s) to be treated are clean with adequate granulation tissue, excellent vascularization, and do not appear infected

	• Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated
	• Medication is prescribed at an FDA approved dose, and maximum weekly dispensing amount is not exceeded.
	  o Vyjuvek: Requests exceeding more than one vial per week will not be approved.
	  o Filsuvez: Documentation of size of treatment area(s) and frequency of dressing changes is required. One tube of Filsuvez covers up to 250 cm^2 surface area per single tube. Requests exceeding use more than once daily will not be approved. Rounding to the next whole tube size necessary is allowed.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Epidiolex (cannabidiol)**
Drugs	Epidiolex (cannabidiol)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Member must be ≥ 1 year old
Prescriber Restrictions	Prescriber must be neurologist or specialist in treatment of seizure disorder.
Coverage Duration	If the criteria are met, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 5/2026	<u>Criteria for Initial Approval:</u> • Diagnosis of Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex • Member has had a trial and failure of two antiepileptic drugs • Member is currently taking a stable dose of at least one other antiepileptic medication • Member's weight has been provided with the request • Dose is within FDA approved limits <u>Reauthorization:</u> • Documentation has been provided that demonstrates reduction or stabilization of seizure frequency • Member's weight has been provided with the request • Dose is within FDA approved limits

Prior Authorization Group Description	**Familial Chylomicronemia Syndrome**
Drugs	Tryngolza (olezarsen), Redemplo (plozasiran)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, lipidologist, or cardiologist or specialist experienced in familial chylomicronemia syndrome (FCS)
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Review/Revision Date: 02/2026
	<u>Initial Authorization:</u>
	• Medication is prescribed at an FDA approved dose
	• The member has undergone genetic testing to confirm a diagnosis of FCS with ONE of the following results:
	  o The member has a pathogenic gene mutation in FCS-causing genes (e.g., *LPL*, *GPIHBP1*, *APOA5*, *APOC2*, or *LMF1*)
	  o The member has inconclusive genetic results and has documentation supporting the diagnosis of FCS by ONE of the following:
	  ▪ North America Familial Chylomicronemia Syndrome (NAFCS) score ≥ 45
	  ▪ FCS score ≥ 10
	  ▪ History of acute pancreatitis
	  ▪ History of recurrent abdominal pain without other known causes
	• The member's most recent triglyceride level is ≥880 mg/dL (10 mmol/L)
	• The member is refractory to standard triglyceride lowering therapies (e.g., statins, fibrates, omega-3 fatty acids, and niacin)
	• The prescriber attests the member will follow a low-fat diet
	• If the request is for Tryngolza, member must also have a trial and failure, intolerance, or contraindication to Redemplo
	
	<u>Re-Authorization:</u>
	• Medication is prescribed at an FDA approved dose
	• Documentation of a positive clinical benefit (e.g., reduction in fasting triglyceride level from baseline, fewer acute pancreatitis events)
	• The prescriber attests the member will continue to follow a low-fat diet
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Fecal Microbiota
Drugs	Rebyota (fecal microbiota, live-jslm) Vowst (fecal micromiota spores, live-brpk)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Treatment of Clostridioides difficile infection (CDI)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for 1 treatment course
Other Criteria Date: 8/2026	• Medication is prescribed at an FDA approved dose • Diagnosis of at least 1 recurrent episode of CDI (≥2 total CDI episodes) • Current episode of CDI must be controlled (<3 unformed/loose stools/day for 2 consecutive days) • Positive stool test for C. difficile within 6 weeks before prior authorization request • Administration will occur 24 to72 hours (for Rebyota only) or 2 to 4 days (for Vowst only) following completion of antibiotic course for CDI treatment • For Vowst only: attestation patient will bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution the day before the first dose of Vowst *Rebyota and Vowst are limited to 1 treatment course* **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Prior Authorization Group Description	**Fintepla (fenfluramine)**
Drugs	Fintepla (fenfluramine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be ≥ 2 years of age
Prescriber Restrictions	Prescriber must be neurologist or specialist in treatment of seizure disorder
Coverage Duration	If the criteria are met, the request will be approved for a 6 month duration
Other Criteria Revision/Review Date 8/2026	**Initial Authorization** • Diagnosis of Lennox-Gastaut or Dravet syndrome • Documented trial and failure or intolerance of at least two antiepileptic drugs • Member is currently taking a stable dose of at least one other antiepileptic medication • Member's weight • Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines **Reauthorization** • Documentation has been provided that demonstrates reduction or stabilization of seizure frequency • Member's weight • Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Forzinity (elamipretide)**
Drugs	Forzinity (elamipretide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	See "Other Criteria"
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a cardiologist, endocrinologist, hematologist, geneticist, neurologist, or other provider specializing in the treatment of Barth Syndrome.
Coverage Duration	If all of the criteria are met, the request will be approved for up to a 12 month duration.
Other Criteria Revision/Review Date: 02/2026	**Initial Authorization:** • Diagnosis of Barth Syndrome confirmed via identification of mutations in the TAZ gene per genetic testing • Member's current weight is provided with the request and is ≥ 30 kg • Pediatrics: patient does not have renal impairment • Adults: patient is not on dialysis • Requested dose is within FDA approved dosing guidelines **Reauthorization:** • Patient has not experienced a serious hypersensitivity reaction to Forzinity • Documentation or provider attestation of clinical benefit (i.e. 6-minute walk test, Total Fatigue Score on the Barth syndrome Symptom Assessment, muscle strength, cardiac function, etc.) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Galafold**
Drugs	Galafold (migalastat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Members should be greater than or equal to 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, cardiologist, nephrologist or specialist experienced in the treatment of Fabry disease
Coverage Duration	If all of the criteria are met, the initial request will be approved for a 6-month duration. If all of the criteria are met, the reauthorization request will be approved for a 12-month duration.
Other Criteria	**Initial Authorization:** • Member has a documented diagnosis of Fabry disease • Member has a documented amenable galactosidase alpha (GLA) gene variant based on in vitro assay data • Member will not be using concurrently with enzyme replacement therapy (e.g., Fabrazyme) • Member has a documented baseline eGFR ≥ 30 mL/min/1.73 m^2 • Request is for an FDA-approved dose **Re-Authorization:** • Member has a documented improvement in symptoms from baseline including but not limited to: decreased pain, decreased gastrointestinal manifestations, decrease in proteinuria, stabilization of increase in eGFR, reduction of left ventricular hypertrophy (LVH) on echocardiogram, or improved myocardial function • Member must not be using concurrently with enzyme replacement therapy (e.g., Fabrazyme) • Member has a documented eGFR ≥ 30 mL/min /1.73 m^2 • Request is for an FDA-approved dose
Revision/Review Date: 08/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Gene Therapy for Hemophilia B**
Drugs	Hemgenix (etranacogene dezaparvovec)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patient has previously received treatment with Hemgenix or Beqvez
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 18 years of age or older
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	If all the criteria are met, the request will be approved for a one-time treatment for one gene therapy agent for Hemophilia B.

Other Criteria
 	
Review Date:
08/2026
	• Diagnosis of Hemophilia B (congenital Factor IX deficiency) with ONE of the following:
	  o Currently using Factor IX prophylaxis therapy
	  o Has current or historical life-threatening hemorrhage
	  o Has repeated, serious spontaneous bleeding episodes
	• Documentation that patient has ≤2% of normal circulating Factor IX
	• Prescriber attests they have performed liver function assessments
	• Documented Factor IX inhibitor titer test showing the patient is negative for Factor IX inhibitors
	• Patient's weight
	• Medication is prescribed at an FDA approved dose
	
	The safety and effectiveness of repeat administration of Hemgenix have not been evaluated and will not be approved.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Erythropoiesis-Stimulating Agents (ESAs)**
Drugs	Preferred: Epogen (epoetin alfa) Retacrit (epoetin alfa-epbx) (Pfizer labeler) Aranesp (darbepoetin alfa-polysorbate 80) Non-preferred: Procrit (epoetin alfa) Retacrit (epoetin alfa-epbx) (Vifor labeler) Mircera (methoxy peg-epoetin beta) –available under medical benefit only for requests for anemia of CKD
Covered Uses	Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If criteria are met, the request will be approved as follows: • For 1 month if the member is deficient in iron, vitamin B12, or folate and in the peri-surgical setting • Up to 3 months for all other requests • If the provider states that the requested medication is for a chronic or long-term condition, reauthorization will be approved for 12 months
Other Criteria	**Existing ESA users who are NEW to the plan:** • Drug is being prescribed for an FDA-approved indication at an FDA-approved dose or is otherwise supported by the compendia or standard-of-care guidelines • Documentation of current dose • The member's hemoglobin (Hgb) is within the following indication-specific range: o Anemia of CKD: Hgb < 11 g/dl o Anemia related to cancer: Hgb ≤ 12 g/dl o Zidovudine-related anemia in members with HIV: Hgb ≤ 12 g/dl o Ribavirin-induced anemia: Hgb ≤ 12 g/dl **Initial Authorization:** • Drug is being prescribed for an FDA-approved indication at an FDA approved dose or is otherwise supported by compendia or standard of care guidelines. • All required labs must have been drawn within 30 days of the request • The following lab values have been submitted: o hemoglobin (Hgb) o hematocrit (HCT) • The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning, therapy to correct the deficiency: o Serum ferritin ≥ 100 ng/mL o Transferrin saturation (TSAT) ≥ 20% o Vitamin B12 level > 223 pg/mL o Folate level > 3.1 ng/mL • If a non-preferred drug is being requested, the member has had a trial of at least two preferred chemically unique drugs within the same drug class, or a trial of at

	least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class; or documentation was provided as to why the member cannot use preferred drugs **Additional Requirements:** For anemia of chronic kidney disease: • Hgb < 10 g/dL For ribavirin-induced anemia: • Member is currently receiving ribavirin and there was a documented attempt at ribavirin dose reduction • Hgb < 12 g/dL For zidovudine-related anemia in members with HIV: • The member is currently receiving highly active antiretroviral therapy (HAART) • Erythropoietin level ≤ 500 mU/mL • Member is receiving a dose of zidovudine ≤ 4,200 mg/week
Revision/Review Date: 11/2025	For anemia related to cancer: • One of the following is true: o Member is receiving myelosuppressive therapy for palliative treatment for at least two months (members receiving myelosuppressive therapy with curative intent should not receive ESAs) AND has documented symptomatic anemia with Hgb <10 g/dL; or o Member has symptomatic anemia related to myelodysplastic syndrome AND documented serum erythropoietin level ≤ 500 mU/ml For members undergoing surgery to reduce the need for allogenic blood transfusion: • Perioperative Hgb must be less than ≤13 g/dL and > 10 g/dL • The member is scheduled for an elective, non-cardiac, nonvascular surgery **Reauthorization:** • All submitted lab results have been drawn within 30 days of the reauthorization request • The following lab results must be submitted: o Hemoglobin (HgB) • The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning, therapy to correct the deficiency: o serum ferritin ≥ 100 ng/mL o transferrin saturation (TSAT) ≥ 20% o vitamin B12 level > 223 pg/mL o folate level > 3.1 ng/mL • The member's hemoglobin is within the following indication-specific range: o For anemia of CKD: Hgb ≤ 11 g/dL o For anemia related to cancer: Hgb ≤ 12 g/dL o For zidovudine-related anemia in members with HIV: Hgb ≤ 12 g/dL o For ribavirin-induced anemia: Hgb ≤ 12 g/dL • An increase in dose has not occurred more than once every 4 weeks **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Generalized Pustular Psoriasis (GPP) Agents**
Drugs	Spevigo (spesolimab-abzo)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or geneticist
Coverage Duration	Acute Flares (IV vial): If all of the criteria are met, the request will be approved for up to 2 doses. Maintenance Treatment (SQ syringe): If all of the criteria are met, the request will be approved for 12 months.

Other Criteria	**Initial Authorization:**
	• Diagnosis of generalized pustular psoriasis (GPP)
	• If request is for an acute GPP flare (IV vial), member must be experiencing an acute flare of GPP of moderate to severe intensity as defined by having all of the following:
	  o Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of 3 or greater
	  o Presence of fresh pustules (new appearance or worsening of pustules)
	  o GPPPGA pustulation sub score of 2 or greater
	  o At least 5% of body surface area covered with erythema and the presence of pustules
	• If request is for maintenance treatment of GPP (SQ syringe), member must have all of the following:
	  o History of at least two GPP flares in the past year of moderate to severe intensity
	  o GPPPGA score of 0 or 1
	  o Documented trial and failure, intolerance, or contraindication to TWO of the following: oral retinoids, methotrexate, and cyclosporine
	• Medication is prescribed at an FDA approved dose
	
	Reauthorization:
	• If request is for an acute GPP flare (IV vial), member must have achieved a clinical response, defined as achieving a GPPPGA score of 0 or 1, to previous treatment and is now experiencing a new flare
	• If request is for maintenance treatment of GPP (SQ syringe), member must have documentation of positive clinical response to therapy (i.e., reduction

Revision/Review Date: 05/2026	in GPP flares) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Givlaari**
Drugs	Givlaari (givosiran)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	If all criteria are met, the initial request will be approved for up to 6 months and reauthorization will be approved for up to 12 months.

Other Criteria
 	
Date: 11/2025
	Initial Authorization:
	• Documented diagnosis of acute hepatic porphyria (AHP)
	• Documentation of one of the following:
	  o Elevation of urinary or plasma porphobilinogen (PBG) ≥ 4 times the upper limit of normal (ULN) within the past 12 months
	  o Elevation of aminolevulinic acid (ALA) values ≥ 4 times the ULN within the past 12 months
	  o Mutation in an affected gene as identified on molecular genetic testing
	• Documentation of active disease, with at least 2 porphyria attacks OR 1 severe attack with central nervous system involvement within the last 6 months, resulting in hospitalization, urgent health care or intravenous administration of hemin
	• Member has not had a liver transplant
	• Documentation of the member's current weight
	• Medication is prescribed at an FDA approved dose
	Reauthorization:
	• Documentation of positive clinical response as represented by one of the following:
	  o Reduction in hemin administration
	  o Reduction in number of porphyria attacks (acute episode of neurovisceral pain in the abdomen, back, chest, extremities and/or limbs)
	• Member has not had a liver transplant
	• Documentation of the member's current weight
	• Medication is prescribed at an FDA approved dose
	
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Prior Authorization Group Description	**Gene Therapies for Spinal Muscular Atrophy**
Drugs	Zolgensma (onasemnogene abeparvovec-xioi) Itvisma (onasemnogene abeparvovec-brve)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Member has previously received this Zolgensma or Itvisma • Advanced spinal muscular atrophy (SMA) (e.g., complete paralysis of limbs, permanent ventilator-dependence) • Administration to premature neonates before reaching full-term gestational age
Required Medical Information	N/A
Age Restrictions	Zolgensma: Member must be less than 2 years of age Itvisma: Patient must be 2 to less than 18 years of age
Prescriber Restrictions	Prescribed by a neurologist
Coverage Duration	If all of the criteria are met, ONE dose may be approved. Reauthorization is not permitted. **The safety and effectiveness of repeat administration of Zolgensma and Itvisma have not been evaluated and will not be approved.**
Other Criteria Revision/Review Date: 02/2026	Patient must meet all of the following criteria: <u>For Zolgensma</u> • Diagnosis of Spinal Muscular Atrophy (SMA) • Bi-allelic mutations in the survival motor neuron 1 (SMN1) gene • Documentation is provided that the member has 3 or fewer copies of the SMN2 gene • Member's body weight • Baseline anti-AAV9 antibody titers of ≤1:50 measured using an enzyme-linked immunosorbent assay (ELISA) • Dosing is consistent with FDA approved labeling <u>For Itvisma</u> • Diagnosis of Spinal Muscular Atrophy (SMA) • Confirmed mutation in the survival motor neuron 1 (SMN1) gene • Onset of clinical signs and symptoms at ≥ 6 months of age • Patient is able to sit independently, but has never had the ability to walk independently • Baseline anti-AAV9 antibody titers of ≤1:50 measured using an enzyme-linked immunosorbent assay (ELISA) • Documentation is provided that the member has 3 or fewer copies of the SMN2 gene • Dosing is consistent with FDA approved labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Gene Therapy for Sickle Cell Disease**
Drugs	Casgevy (exagamglogene autotemcel) Lyfgenia (lovotibeglogene autotemcel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Repeat use of same gene therapy agent Trial of a different gene therapy agent after another has been used
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a hematologist or specialist in the treatment of sickle cell disease
Coverage Duration	If all of the criteria are met, the request will be approved for a one-time treatment **for one gene therapy agent.**

Other Criteria
 	
Revision/Review Date: 2/2026
	• Medication is prescribed at an FDA approved dose
	• Member has a diagnosis of sickle cell disease
	• Member has experienced at least 2 severe vaso-occlusive crises/events per year in the past 2 years defined as either:
	  o VOE requiring a hospitalization or multiple visits to an emergency department/urgent care over 72 hours and receiving intravenous medications at each visit
	  o Priapism lasting > 2 hours and requiring a visit to a medical facility
	  o Acute chest syndrome
	  o Splenic sequestration
	  o Hepatic sequestration
	• Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose and has been compliant within the last 6 months (or a medical reason was provided why the patient is unable to use hydroxyurea)
	• Documentation was provided that the member had a trial and failure of, or a medical reason was provided why the patient is unable to trial one of the following agents:
	  o L-glutamine (Endari)
	  o Adakveo
	• Prescriber attests pregnancy has been ruled out prior to initiation of treatment (if applicable)
	• Patient has not had a prior HSCT or gene therapy treatment
	• If the request is for Lyfgenia, a medical reason must be submitted why the patient is unable to use Casgevy.
	
	The safety and effectiveness of repeat administration of Casgevy or Lyfgenia have not been evaluated and will not be approved.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Gene Therapy for Regular Red Blood Cell (RBC) Transfusion Dependent Beta-Thalassemia**
Drugs	Zynteglo (betibeglogene autotemcel) Casgevy (exagamglogene autotemcel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Repeat use of same gene therapy agent Trial of a different gene therapy agent after another has been used
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	If all of the criteria are met, the request will be approved for a one-time treatment for **one gene therapy agent**.

Other Criteria
 	
Revision/Review: Date: 2/2026
	• Medication is prescribed at an FDA approved dose
	• Member has a diagnosis of transfusion dependent beta-thalassemia
	• Member requires regular RBC transfusions defined as ONE of the following:
	  o History of ≥100 mL/kg/year of packed red blood cell (pRBCs) in the past 2 years
	  o History of ≥8 transfusions of pRBCs per year in the past 2 years
	• Patient has not had a prior hematopoietic stem-cell transplantation (HSCT) or gene therapy treatment
	• If the request is for Zynteglo, a medical reason must be submitted why the patient is unable to use Casgevy.
	• Negative pregnancy test (if applicable)
	
	The safety and effectiveness of repeat administration of Zynteglo have not been evaluated and will not be approved.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Gonadotropin Releasing Hormone (GNRH) Agonists** **If diagnosis is cancer, use oncology drugs/therapies criteria**
Drug(s)	**Preferred GnRH Agonists for their respective indications:** Zoladex (goserelin acetate) Lupron Depot (leuprolide acetate) Lupron Depot-Ped (leuprolide acetate) **Non-Preferred GnRH Agonists** Fensolvi (leuprolide acetate) Supprelin LA (histrelin acetate) Synarel (nafarelin) Trelstar (triptorelin pamoate) Triptodur (triptorelin pamoate) And any newly marketed GnRH agonist
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO), the American College of Obstetricians and Gynecologists (ACOG), or the American Academy of Pediatrics (AAP) standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See Other Criteria
Age Restrictions	According to package insert if not detailed in "Other Criteria"
Prescriber Restrictions	Gynecologist, Endocrinologist, or any Specialist in the field that treats the member's condition
Coverage Duration	If all of the conditions are met, the request will be approved for 12 months, except for the following medical conditions: • Endometriosis: 6 months • Uterine leiomyomas (fibroids): 3 months • Endometrial thinning to prepare for endometrial ablation: 3 months
Other Criteria	**<u>INITIAL AUTHORIZATION for ALL REQUESTS:</u>** • The medication is prescribed for an FDA approved or standard of care guideline indication and within FDA approved or standard of care dosing guidelines. **AND the member meets the following for the respective diagnosis:** <u>Central precocious puberty (CPP)</u> • Onset of secondary sexual characteristics less than age 8 in females and age 9 in males • Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and/or measurement of gonadotropins (FSH/LH), and bone age advanced beyond chronological age. o Patients with low or intermediate basal levels of LH should have a GnRH stimulation test to clarify the diagnosis ▪ *If basal levels of LH are markedly elevated [e.g. more than 0.3mlU/ml (where IU- International units)] in a child with*

	precocious puberty, then a diagnosis of CPP can be made without proceeding to a GnRH stimulation test. • Brain magnetic resonance imaging (MRI) has been performed for all boys with CPP and for girls with onset of secondary sexual characteristics before the age of six years of age to rule out a tumor. • If the request is for any agent other than Lupron Depot-Ped the member has a documented trial and failure with Lupron Depot-Ped or medical reason (e.g. contraindication, hypersensitivity, intolerance) as to why the member is not able to use Lupron-Depot Ped <u>Endometriosis</u> • Confirmed diagnosis of endometriosis and all of the following: o Documented trial and failure or medical reason for not using an analgesic pain reliever (e.g., NSAIDs, COX-2 inhibitors) taken in combination with combined estrogen progestin oral contraceptive pills (OCPs) ▪ <u>If one of the following drugs has been tried previously, a trial of OCPs is not required: progestins, Orilissa (elagolix), Myfembree (relugolix/estradiol/norethindrone), danazol, or an aromatase inhibitor (e.g. anastrozole, letrozole)</u> o If the request is for any agent other than Lupron Depot or Zoladex, the member has had a documented trial and failure with Lupron Depot or Zoladex or a documented medical reason (e.g., intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Lupron Depot or Zoladex o Member will receive one of the following in conjunction with GNRH agonist therapy: ▪ norethindrone acetate 5 mg daily ▪ conjugated estrogen therapy ▪ oral bisphosphonate AND calcium and vitamin D supplementation <u>Uterine leiomyomas (Fibroids)</u> • Documented diagnosis of uterine fibroids • If the request is for any agent other than Lupron Depot, the member has had a documented trial and failure with Lupron Depot or a documented medical reason (e.g., intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Lupron Depot <u>Endometrial thinning</u> • Documentation was submitted indicating the member is scheduled for endometrial ablation for dysfunctional uterine bleeding • If the request is for any agent other than Zoladex, the member has a documented trial and failure with Zoladex or a documented medical reason (e.g., intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Zoladex **<u>REAUTHORIZATION criteria for all requests:</u>** • The medication is being prescribed for an FDA approved or standard of care guideline indication and within FDA approved or standard of care dosing

Revision/Review Date: 8/2026	guidelines. • Documentation was provided supporting continued treatment (e.g. patient still has symptoms), and medication is being continued as recommended in package insert or standard of care guidelines. **<u>AND meets the following per diagnosis:</u>** <u>Central precocious puberty (CPP)</u> • If the medication reauthorization is for central precocious puberty, the child is male and < 12 years or female and < 11 years of age OR a documented medical reason to continue treatment was provided with request, and includes current height and bone age <u>Endometriosis</u> • Prescriber has evaluated member for osteoporosis (e.g. Dexa scan) • Member will receive one of the following in conjunction with GNRH agonist therapy: o norethindrone acetate 5 mg daily o conjugated estrogen therapy o oral bisphosphonate AND calcium and vitamin D supplementation • The member has not received cumulative doses of the GnRH agonist greater than 12 months of therapy. <u>Fibroids</u> • The member has not received cumulative doses of the GnRH agonist greater than 6 months of therapy **NOTE: Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Gonadotropin Releasing Hormone Antagonists**
Drugs	Orilissa (elagolix) Oriahnn (elagolix, estradiol, and norethindrone acetate) Myfembree (relugolix, estradiol, and norethindrone acetate)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	• Pregnancy • History of osteoporosis • History of hepatic impairment (Myfembree, Oriahnn), or severe hepatic impairment (Orilissa)
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Prescriber must be an obstetrician/gynecologist
Coverage Duration	If the criteria are met, the request will be approved as outlined below: • Initial Authorization: 6 months • Reauthorization: 6 months • Eligible maximum lifetime treatment duration: 24 months

Other Criteria	<u>Initial Authorization for all requests:</u>
	• Medication is prescribed at an FDA approved dose
	
	<u>For a diagnosis of endometriosis associated with moderate to severe pain:</u>
	• Request is for Orilissa or Myfembree only
	• Documented trial and failure or medical reason for not using analgesic pain reliever (ex. NSAIDs, COX-2 inhibitors, opioids) taken in combination with combined estrogen-progestin oral contraceptives
	  o If one of the following drugs has been tried previously, a trial of oral contraceptives is not required: progestins (oral, implant, or intrauterine device), gonadotropin-releasing hormone (GnRH) agonists, aromatase inhibitors (e.g. letrozole, anastrozole), or danazol
	
	<u>For a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids):</u>
	• Request is for Oriahnn or Myfembree only
	• Documented trial and failure or medical reason for not using estrogen-progestin contraceptive therapy
	• If one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required:
	  o GnRH agonists,
	  o progestin-releasing intrauterine device
	  o tranexamic acid
	
	<u>Reauthorization:</u>
	• Maximum lifetime treatment duration based on previous dosing and/or hepatic functioning has not been exceeded

Revision/Review Date: 2/2026	• Documentation or provider attestation of positive clinical response (e.g., reduction in pain, reduced heavy menstrual bleeding). • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group	**Growth Hormone (GH) for Growth Failure or GH Deficiency**
Drug(s)	**Preferred:** Norditropin FlexPro, NuSpin, Zomacton **Non-preferred:** Humatrope, Omnitrope, Skytrofa, Sogroya, Ngenla, Genotropin MiniQuick, cartridge and any newly marketed growth hormone agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Treatment of idiopathic short stature (ISS) is not a covered benefit and will not be approved
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or specialist in the stated diagnosis
Coverage Duration	If all of the conditions are met, the request will be approved for 12 months.
Other Criteria	**Initial Authorization** • If a non-preferred drug is being requested, the member has had a trial of at least two preferred growth hormone drugs or documentation was provided as to why the member cannot use preferred growth hormone drugs • The requested dose is appropriate per compendia • If diagnosis is growth failure associated with **Prader-Willi Syndrome, Noonan Syndrome, Turner's Syndrome, or short stature homeobox-containing gene (SHOX)** mutation, or other underlying genetic cause, the confirmatory genetic test has been documented with the request • If diagnosis is **growth failure associated with chronic kidney disease (CKD)**, documentation has been provided for the following: o Pretreatment height is less than -1.88 standard deviations (SD) below the mean for age OR height velocity for age is less than 3rd percentile and has persisted for more than 3 months AND o Epiphyses are open • If diagnosis is **adult-onset growth hormone deficiency (AO-GHD),** documentation of one of the following: o Insulin Growth Factor (IGF-1) deficiency (less than -2 SD below reference range for age and sex*) and multiple (≥3) pituitary hormone deficiencies (MPHD) o Evidence of genetic defects affecting the hypothalamic pituitary adrenal (HPA) axis o Evidence of hypothalamic pituitary structural brain defects o Positive results of GH stimulatory test (e.g., insulin tolerance test

Revision/Review Date: 2/2026	(ITT), glucagon stimulation test, or macimorelin stimulation test)
	• If diagnosis is **childhood-onset GH deficiency (CO-GHD)**:
	  ○ And patient is currently pediatric, documentation of all of the following is required:
	  ▪ IGF-1 and insulin-like growth factor binding protein-3 (IGFBP-3) deficiency (less than 0 SD below reference range for age and sex)* with prescriber attestation of growth failure
	  ▪ Provider attests that MRI or CT has been completed to exclude possibility of a pituitary tumor
	  ▪ Provider attests that member's epiphyses are open
	  ○ And patient is currently adult, documentation of one of the following is required:
	  ▪ If diagnosis is idiopathic isolated GHD, documentation provided that indicates GH therapy is still medically necessary (IGF-1 retesting during the transition period after a minimum 1 month of therapy discontinuation reveals continued GH deficiency)
	  ▪ Diagnosis is GHD associated with MPHD, genetic defect affecting the HPA axes, or patient with hypothalamic pituitary structural brain defect
	
	<u>Reauthorization</u>
	• Documentation of diagnosis (Note: idiopathic short stature is not a covered benefit)
	• Documented IGF-1 do not exceed upper limit of normal (ULN) (>2 SDs above reference range for age and sex)*, or if the IGF-1 levels do exceed ULN, the dose has been reduced
	• In CO-GHD patients, the prescriber indicates a positive growth response has occurred with growth hormone therapy as demonstrated by length/height and calculated height velocity within previous 6 months
	
	*IGF-1 levels are highly age and sex specific. In the event the lab report provides a value and not the corresponding reference range, refer to published reference ranges for interpretation. (example: https://www.labcorp.com/tests/010363/insulin-like-growth-factor-1-igf-1)
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Subcutaneous Treatments for Hemophilia**
Drugs	Hemlibra (emicizumab-kxwh), Hympavzi (marstacimab-hncq), Alhemo (concizumab-mtci), Qfitlia (fitusiran)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	If the criteria are met, requests will be approved for 6 months. If the provider states that the requested medication is for a chronic or long-term condition for which the medication may be necessary for the life of the patient, the request will be approved for 12 months.
Other Criteria Revision/ Review Date: 08/2026	**<u>Initial Authorization</u>:** Documentation submitted indicates the following: • The member's weight • The drug is being requested for an FDA-approved indication and the dose is within FDA-indicated limits • Diagnosis of hemophilia A or hemophilia B AND one of the following: o Request is for routine prophylaxis in a member with a diagnosis of hemophilia A or hemophilia B **WITH** inhibitors and history of spontaneous or traumatic bleeding episode o Request is for routine prophylaxis in a member with a diagnosis of hemophilia A or hemophilia B **withOUT** inhibitors and patient requires management with Factor VIII or Factor IX products at a total weekly dose of > 100 U/kg (attestation must be submitted by prescriber) o Patient has tried Factor VIII or factor IX products and is not well managed due to limited venous access or treatment failure (attestation must be submitted from prescriber) • If the request is for Hympavzi, Qfitlia or Alhemo for hemophila A, the member must also have a trial and failure or intolerance to Hemlibra • If the request is for Qfitlia, prescriber must also attest to monitoring member antithrombin (AT) levels, signs and symptoms of thrombotic events, and signs and symptoms of acute and recurrent gallbladder disease as recommended per the manufacturer's prescribing information

	<u>Re-Authorization:</u> • Documentation submitted indicating the member has experienced a clinical benefit from the medication (e.g. reduction in bleeding episodes, improved quality of life) and has discontinued factor VIII inhibitor or BPA prophylaxis (where applicable) • The patient's weight • Dose is within FDA-indicated limits **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Treatment of Hereditary Angioedema (HAE)**
Drugs	**Preferred:** Berinert (C1 esterase inhibitor, human) Cinryze (C1 esterase inhibitor, human) icatibant (Firazyr) **Non-preferred:** Haegarda (C1 esterase inhibitor, human) Ruconest (C1 esterase inhibitor, recombinant) Kalbitor (ecallantide) Takhzyro (lanadelumab-flyo) Orladeyo (berotralstat) Firzyr (icatibant) Ekterly (sebetralstat) Andembry (garadacimab-gxii) Dawnzera (donidalorsen) or any newly marketed agent *If the request is for danazol, please refer to the danazol PA criteria*
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by an immunologist, allergist, rheumatologist, or hematologist

Coverage Duration	If all of the criteria are met, the request will be approved as follows:
	• Acute treatment: Initial fill + 5 refills
	• Pre-procedural prophylaxis: 1 treatment
	• Long-term prophylaxis:
	  o Initial: 6 months
	  o Reauthorization: 12 months

Other Criteria	**<u>Initial Criteria</u>**
	• Dose is appropriate for indication per compendia
	• The member is not taking ACE inhibitors, estrogen-containing oral contraceptives, or hormone replacement therapy
	• Documented diagnosis of one of the following:
	  1. HAE with deficient or dysfunctional C1INH (e.g., type I, type II, or acquired C1INH deficiency)
	  2. HAE with normal C1INH:
	  ▪ If known origin, documentation of results of confirmatory genetic test (e.g., mutations in gene for factor XII, angiopoietin-1, plasminogen, kininogen-

Revision/Review Date: 11/2025	1, myoferlin, heparan sulfate-glucosamine 3-*O*-sulfotransferase 6) ▪ If unknown origin (U-HAE), documentation of a prolonged trial of high-dose non-sedating antihistamines **For acute treatment (Berinert, icatibant, Kalbitor, Ruconest, Sajazir, Ekterly):** • The patient is receiving only one agent for the treatment of acute attacks. • If the request is for a non-preferred drug, the member has documented trial and failure of, or intolerance to, Berinert or icatibant **For pre-procedural prophylaxis (Cinryze, Haegarda, Orladeyo, Takhzyro, Andembry, Dawnzera):** • Documentation that patient will be undergoing a medical, surgical, or dental procedure associated with mechanical impact to the upper aerodigestive tract and anticipated date of the procedure **For long-term prophylaxis (Cinryze, Haegarda, Orladeyo, Takhzyro, Andembry, Dawnzera):** • The patient has a history of at least two severe attacks per month (e.g., swelling of the face, throat, or GI tract) or at least one laryngeal attack • The patient is only receiving one HAE medication for long-term prophylaxis • If the request is for a non-preferred drug, the member has documented trial and failure of, or intolerance to, Cinryze **<u>Reauthorization Criteria:</u>** **For acute treatment (Berinert, icatibant, Kalbitor, Ruconest, Sajazir, Ekterly):** • Dose is appropriate for indication per compendia • Documentation was submitted that the patient has clinically benefited from medication • The patient is receiving no other medications for acute treatment **For prophylaxis (Cinryze, Haegarda, Orladeyo, Takhzyro, Andembry, Dawnzera):** • Dose is appropriate for indication per compendia • Documentation was submitted that the patient has clinically benefited from prophylactic therapy as demonstrated by a reduced number of attacks • The patient is receiving no other medications for prophylaxis **Medical Director/Clinical Reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary**

Field Name	Field Description
Prior Authorization Group Description	**Hydroxyprogesterone caproate (generic Delalutin)**
Drugs	Hydroxyprogesterone caproate (generic Delalutin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Pregnancy
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a gynecologist or in consultation with a gynecologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for up to 6 months. For reauthorization, the request will be approved for up to 6 months.
Other Criteria Revision/Review Date: Date: 02/2026	**<u>Initial Authorization:</u>** • Medication is prescribed at an FDA approved dose • If request is for preterm birth, do not approve • Request is for one of the following indications: o Amenorrhea or abnormal uterine bleeding due to hormonal imbalance o Production of secretory endometrium and desquamation o Test for endogenous estrogen production o Advanced uterine adenocarcinoma **<u>Re-Authorization:</u>** • Documentation or provider attestation of clinical benefit • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Ileal bile acid transporter (IBAT) inhibitors**
Drugs	Bylvay (odevixibat), Livmarli (maralixibat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	per prescribing information
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist
Coverage Duration	If the conditions are met, the request will be approved for a 6 month duration for initial requests and a 12 month duration for renewal requests.

Other Criteria	**Initial Authorization:**
	
	Progressive Familial Intrahepatic Cholestasis
	• Diagnosis of progressive familial intrahepatic cholestasis (PFIC)
	  o For Bylvay: PFIC type 1 or 2 with confirmed biallelic mutations via genetic testing.
	  o For Livmarli: PFIC type 1, 2, 3, 4 or 6, with confirmed biallelic mutations via genetic testing
	• Documentation that patient does not have an *ABCB11* variant that results in non-functional or complete absence of bile salt export pump protein (BSEP-3)
	• Documented history of moderate to very severe pruritus
	• Documentation of patient's weight
	• Prescriber attests to monitor liver function tests and fat soluble vitamin (FSV) levels during treatment
	• Baseline serum bile acid level
	• Documentation of trial and failure ORcontraindication to at least TWO of the following:
	  o Ursodiol
	  o Cholestyramine or colesevelam
	  o Rifampin
	  o Fibrates (ex. fenofibrate)
	• The prescribed dose is within FDA approved dosing guidelines

Revision/Review Date: 8/2026	**<u>Alagille Syndrome</u>**
	• Diagnosis of Alagille syndrome (ALGS)
	• Documented history of moderate to very severe pruritus
	• Baseline serum bile acid level is provided
	• Documentation of member's weight
	• Prescriber attests to monitor liver function tests and fat soluble vitamin (FSV) levels during treatment
	• Documentation of trial and failure OR contraindication to at least TWO of the following:
	  o Ursodiol
	  o Cholestyramine or colesevelam
	  o Rifampin
	  o Fibrates (ex. fenofibrate)
	• Prescriber attests that the member has cholestasis
	• The prescribed dose is within FDA approved dosing guidelines
	
	<u>Reauthorization:</u>
	• Documentation of clinical benefit indicated by the following:
	  o An improvement in pruritus (e.g. improved observed scratching, decreased sleep disturbances/nighttime awakenings due to scratching, etc.) AND
	  o Reduction in serum bile acid level from baseline
	• Documentation of patient's weight
	• Prescriber attests to monitor liver function tests and FSV levels during treatment
	• Prescriber attests that patient has had no evidence of hepatic decompensation (e.g. variceal hemorrhage, ascites, hepatic encephalopathy, portal hypertension, etc.)
	• The prescribed dose is within FDA approved dosing guidelines
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Myasthenia Gravis Agents
Drugs	Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase), Rystiggo (rozanolixizumab), Soliris (eculizumab), Ultomiris (ravulizumab), Zilbrysq (zilucoplan), BKEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh), Imaavy (nipocalimab-aahu)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or rheumatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria	**Initial Authorization:**
	• For diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy, refer to the "Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents" policy
	• Diagnosis of generalized myasthenia gravis (gMG)
	• Patient has a positive serological test for one of the following:
	  o Anti-AChR antibodies
	  o Anti-muscle-specific tyrosine kinase (MuSK) antibodies (Rystiggo and Imaavy only)
	• Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II, III or IV
	• Patient has tried and failed, or has contraindication, to one of the following:
	  o Trial and failure of at least 1 conventional therapy (i.e. acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies)
	  o Patient requires maintenance plasma exchange or intravenous immunoglobulin to control symptoms
	• Medication is prescribed at an FDA approved dose
	• Patient is not using agents covered by this policy concurrently (i.e., no concurrent use of Vyvgart, Vyvgart Hytrulo, Rystiggo, Soliris, Ultomiris, BKEMV, Epysqli, Imaavy, or Zilbrysq)

	• Requests for Imaavy, Soliris (eculizumab), Ultomiris (ravulizumab), BKEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh), and Zilbrysq (zilucoplan) will also require the following: o Documentation patient complies with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal infections in patients receiving a complement inhibitor. o **<u>Re-Authorization:</u>** • Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality-of-life scores, MG-ADL scores, etc). • Medication is prescribed at an FDA approved dose. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Revision/Review Date: 8/2025	

Field Name	Field Description
Prior Authorization Group Description	Immunoglobulin A (IgA) Nephropathy Agents
Drugs	Fabhalta (iptacopan), Filspari (sparsentan), Tarpeyo (budesonide), Vanrafia (atrasentan), Voyxact (sibeprenlimab-szsi)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	For Filspari and Vanrafia only: • Pregnancy
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist
Coverage Duration	If all of the criteria are met, the criteria will be approved as follows: Initial requests: • 6 months: Fabhalta • 9 months: Filspari, Tarpeyo, Vanrafia, Voyxact, Reauthorization: • 12 months: Fabhalta, Filspari, Vanrafia, Voyxact • Reauthorization requests for Tarpeyo will not be allowed as the safety and efficacy of subsequent courses have not been established
Other Criteria	**Initial Authorization:** • Diagnosis of primary IgA nephropathy verified by biopsy • Member is on an ACE inhibitor or ARB at a maximally tolerated dose OR there is a medical reason that they cannot be on one • Member has proteinuria (defined as total urine protein ≥0.5 g/day) • Member has an estimated glomerular filtration rate (eGFR) ≥30 mL/min/1.73 m^2 • Medication is prescribed at an FDA approved dose • For Fabhalta: o Documentation patient complies with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria o Member is at risk for disease progression as defined by a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g • For Filspari: o Documentation of baseline liver function o Attestation that member will discontinue use of renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists, and/or aliskiren upon initiation of Filspari • For Vanrafia: o Member is at risk for disease progression as defined by a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g **Re-Authorization:** • Documentation of positive clinical response (e.g. decrease in UPCR, stabilization of eGFR) • Medication is prescribed at an FDA approved dose • For Filspari:

	○ Documentation of liver function ***Reauthorization requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established***
Review/Revision Date: 2/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Immune Globulins**
Drugs	Gamunex-C (IV or SQ) (Immune Globulin) – preferred for all applicable indications Bivigam (IV) (Immune Globulin) Cuvitru (SQ) (Immune Globulin) Flebogamma (IV) (Immune Globulin) Gammagard liquid (IV or SQ) (Immune Globulin) Gammagard SD (IV) (Immune Globulin) Gammaked (IV or SQ) (Immune Globulin) Gammaplex (IV) (Immune Globulin) Hizentra (SQ) (Immune Globulin) Octagam (IV) (Immune Globulin) Privigen (IV) (Immune Globulin) Asceniv (IV) (Immune Globulin-slra) Cutaquig (SQ) (Immune Globulin-hipp) Panzyga (IV) (Immune Globulin-ifas) Hyqvia (SQ) (Immune Globulin Human/Recombinant Human Hyaluronidase) Xembify (SQ) (Immune Gobulin-klhw) Alyglo (IV) (Immune Globulin-stwk) or any newly-approved immune globulin product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See “other criteria”
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber is a specialist in disease state being treated
Coverage Duration	If all of the criteria are met, the request will be approved for a 3 month duration unless otherwise specified in the diagnosis specific “Other Criteria” section below.
Other Criteria	**<u>All Requests:</u>** • Documentation of diagnosis confirmed by a specialist • Member has tried and failed, or has a documented medical reason for not using, all other standard of care therapies as defined per recognized guidelines • Member’s height and weight are provided • Dosing will be calculated using ideal body weight (IBW), unless ONE of the following:

	○ If the member's actual weight is less than their IBW, then dosing will be calculated using their actual weight ○ If the member's body mass index (BMI) is ≥30 kg/m^2 OR if their actual weight is greater than 20% of their IBW, then dosing will be calculated using adjusted body weight (adjBW) **<u>Primary Immunodeficiency*</u>**: • Patient's IgG level is provided and is below normal level for indication, or a documented specific antibody deficiency • Clinically significant deficiency of humoral immunity as evidenced by ONE of the following: ○ Inability to produce an adequate immunologic response to specific antigens ○ History of recurrent infections despite prophylactic antibiotics • Dose is consistent with FDA approved package labeling, nationally recognized compendia, or peer-reviewed literature • If the request is for any medication other than Gamunex-C, the member has tried and failed, or has a documented medical reason for not using, Gamunex-C • If criteria are met, approve for 6 months *Primary Immunodeficiency includes, but is not limited to, the following: Congenital agammaglobulinemia, hypogammaglobulinemia (Common Variable Immunodeficiency, CVID), severe combined immunodeficiency (SCID), Wiskott-Aldrich syndrome, X-linked agammaglobulinemia or Bruton's agammaglobulinemia, hypergammaglobulinemia, X-linked hyper IgM syndrome **<u>Idiopathic Thrombocytopenic Purpura, acute and chronic</u>**: • <u>Acute</u>: ○ Patient has active bleeding, is requiring an urgent invasive procedure, is deferring splenectomy, has platelet counts < 20,000/ul at risk for intra-cerebral hemorrhage or life threatening bleeding, or has an inadequate increase in platelets from corticosteroids or unable to tolerate corticosteroids ○ Dose does not exceed 1g/kg daily for up to 2 days, or 400 mg/kg daily for 5 days • <u>Chronic:</u> ○ Duration of illness is greater than 12 months ○ Patient has documented trial and failure of corticosteroids and splenectomy, or has a documented medical reason why they are not able to use corticosteroids or member is at high risk for post-splenectomy sepsis. ○ Dose does not exceed 1g/kg daily for up to 2 days, or 400 mg/kg daily for 5 days

	• If the request is for any medication other than Gamunex-C, the member has tried and failed, or has a documented medical reason for not using, Gamunex-C • If criteria are met, approve for up to 5 days. **Kawasaki disease:** • Immune globulin is being given with high dose aspirin, unless contraindicated • Requested dose does not exceed a single 2 g/kg dose. • If criteria are met, approve for up to 1 dose **Chronic B-cell lymphocytic leukemia:** • Patient's IgG level is <500 mg/dL • The patient has had recurrent infections requiring IV antibiotics or hospitalization • Dose does not exceed 500 mg/kg every 4 weeks • If criteria are met, approve for 3 months. **Bone marrow transplantation:** • The patient has bacteremia or recurrent sinopulmonary infections and their IgG level is < 400mg/dL • Dose does not exceed 500 mg/kg/week for the first 100 days post- transplant • Dose does not exceed 500 mg/kg every 3-4 weeks 100 days after transplant • If criteria are met, approve for 3 months. **Pediatric HIV**: • Patient is < 13 years of age • Either patient's IgG level is < 400mg/dL or if patient's IgG level is ≥ 400 mg/dL then significant deficiency of humoral immunity as evidenced by ONE of the following: o Inability to produce an adequate immunologic response to specific antigens. o History of recurrent bacterial infections despite prophylactic antibiotics • Dose does not exceed 400 mg/kg/dose every 2 to 4 weeks • If criteria are met, approve for 3 months. **Multifocal motor neuropathy (MMN)**: • Duration of symptoms has been at least 1 month with disability. • Nerve conduction studies were completed to rule out other possible conditions, and confirms the diagnosis of MMN. • Dose does not exceed 2.4 g/kg/month administered over 2-5 days. • If criteria are met, approve for up to 5 days per course for 6 months.

Revision/Review Date: 11/2025	**<u>Chronic inflammatory demyelinating polyneuropathy (CIDP)</u>:**
	• Duration of symptoms has been at least 2 months with disability.
	• Nerve conduction studies or a nerve biopsy were completed in order to rule out other possible conditions, and confirms the diagnosis of CIDP.
	• Patient has a documented trial and failure of, or has a documented medical reason for not using, corticosteroids
	  o If the patient has severe and fulminant CIDP, a trial of corticosteroids is not required
	  o In pure motor CIPD a trial of corticosteroids in not required
	• Dose is consistent with FDA approved package labeling, nationally recognized compendia, or peer-reviewed literature
	• If the request is for any medication other than Gamunex-C, the member has tried and failed, or has a documented medical reason for not using, Gamunex-C
	• If criteria are met, approve for 3 months
	
	<u>Guillain-Barre syndrome</u>:
	• Patient has severe disease with the inability to walk without aid
	• Onset of symptoms within the last 4 weeks
	• Dose does not exceed 2 g/kg given over 5 days per month
	• If criteria are met, approve for up to 5 days.
	
	<u>Myasthenia Gravis</u>:
	• <u>Acute</u>:
	  o Patient has an acute myasthenic exacerbation (i.e., acute episode of respiratory muscle weakness, difficulty swallowing, etc.) or is in preparation for thymoma surgery to prevent myasthenic exacerbation
	  o Dose does not exceed 2 g/kg administered over 2-5 days
	  o If criteria is met, approve for up to 5 days
	• <u>Chronic:</u>
	  o Diagnosis of refractory generalized myasthenia gravis
	  o Patient has a documented trial and failure of, or has a documented medical reason for not using, 2 or more immunosuppressive therapies (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil)
	  o Dose does not exceed 2 g/kg/month administered over 2-5 days
	  o If criteria is met, approve for 3 months.
	
	<u>Dermatomyositis (DM):</u>
	• One of the following:

	○ Bohan and Peter score of 3 (i.e. definite DM) ○ Bohan and Peter score of 2 (i.e. probable DM) AND concurring diagnostic evaluation by ≥ 1 specialist (e.g. neurologist, rheumatologist, dermatologist) • Patient does NOT have any of the following: ○ Cancer associated myositis defined as myositis within 2 years of cancer diagnosis (except basal or squamous cell skin cancer or carcinoma in situ of the cervix that has been excised and cure) ○ Active Malignancy ○ Malignancy diagnosed within the previous 5 years ○ Breast cancer within the previous 10 years • For a diagnosis of DM, one of the following: ○ Patient has a documented trial and failure of, or has a documented medical reason for not using both of the following: ▪ methotrexate (MTX) OR azathioprine ▪ rituximab ○ Patient has severe, life-threatening weakness or dysphagia • For a diagnosis of cutaneous DM (i.e. amyopathic DM, hypomyopathic DM): ○ Patient has a documented trial and failure of, or has a documented medical reason for not using, all of the following: ▪ MTX ▪ mycophenolate mofetil • Dose does not exceed 2 g/kg administered over 2-5 days every 4 weeks. • If criteria is met, approve for up to 3 months. If criteria is met, the request will be approved for the duration listed above. **Medical Director/Clinical Reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary**

Prior Authorization Group Description	**Immunosuppressants for Lupus Nephritis**
Drugs	Lupkynis (voclosporin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist or other specialist in the treatment of autoimmune disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 5/2026	**<u>Initial Authorization</u>** • Member must have a diagnosis of systemic lupus erythematosus (SLE) with a kidney biopsy indicating a histologic diagnosis of lupus nephritis (LN) Class III, IV, or V • Documentation that the member has a baseline eGFR > 45 mL/min/1.73m^2 • Documentation of the member's urine protein/creatinine ratio (UPCR) is provided • Member is concurrently being treated with background immunosuppressive therapy, or has a medical reason for not using background immunosuppressive therapy • Member is NOT concurrently being treated with cyclophosphamide • Medication is prescribed at an FDA approved dose **<u>Reauthorization</u>** • Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR ≥ 20%) • Prescriber attestation that eGFR will be assessed quarterly • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Inhaled Cystic Fibrosis Agents**
Drug(s)	Preferred: Bethkis Kitabis Pak generic tobramycin 300mg/5mL (Tobi) Non-preferred: Cayston (aztreonam lysine) Tobi/Tobi Podhaler generic tobramycin 300mg/4mL (Bethkis) Non-formulary: Pulmozyme (dornase alfa) or any newly marketed inhaled antibiotic or cystic fibrosis treatment
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	See "Other Criteria"
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a pulmonologist or infectious disease specialist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 months
Other Criteria Review/Revision Date: 8/2026	• Request is for an FDA-approved indication and within dosing guidelines • If the request is for Pulmozyme (dornase) for a member with **mild** disease, a trial of generic hypertonic saline nebulization solution (sodium chloride 3% or 7%) is required • If the request is for a PDL non-preferred product, documentation that the member has had a trial of one of the preferred drugs for a duration of at least two 28-day cycles, or the member has a contraindication, intolerance, or clinical reason why the preferred drugs are not appropriate. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Injectable Antiemetics: 5-Hydroxytryptamine-3 (5HT3) Serotonin Receptor Antagonists and Substance P/Neurokinin 1 Receptor Antagonists (NK1 RA)**
Drugs	**Non formulary:** granisetron (Kytril) IV solution ondansetron (Zofran) IV solution, SubQ injection palonosetron (Aloxi) IV solution Sustol (granistron ER SubQ injection) Cinvanti (aprepitant) IV emulsion Varubi (rolapitant) IV emulsion fosaprepitant (Emend) IV emulsion Focinvez IV solution Posfrea (palonosetron) IV solution Brekiya (dihydroergotamine mesylate) subQ injection Any other newly marketed agent
Covered Uses	The request for the medication is for and Food and Drug Administration (FDA) approved indication, and/or is used for a medical condition that is supported by the medical compendium and/or per the National Comprehensive Cancer Network (NCCN) or American Society of Clinical Oncology (ASCO) standard of care guidelines for antiemetic therapy.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a specialist in a field appropriate for treatment of the patient's respective medical condition.
Coverage Duration	If all of the conditions are met, the request may be approved for up to 6 months or as long as recommended by medical compendia and/or per NCCN or ASCO standard of care guidelines.

Other Criteria	• The medication is being requested for a Food and Drug Administration (FDA) approved indication or a medical condition that is supported by the medical compendia, NCCN, or ASCO standard of care guidelines for antiemetic therapy
	• Requested dose must be FDA-approved or within NCCN or ASCO guidelines
	• For requests for injectable ondansetron and granisetron: a trial and failure of (or documented medical reason for not using) oral ondansetron is required
	• If the request is for a medication other than generic ondansetron or generic granisetron, the member must have a documented trial and failure of (or documented medical reason for not using) all of the following:
	  o Oral ondansetron
	  o Injectable ondansetron or granisetron
	• Adult members receiving an antineoplastic agent with HIGH or MODERATE emetic risk per the NCCN practice guidelines may be

Revision/Review Date: 8/2026	approved for generic palonosetron without prior trial and failure of ondansetron/granisetron • Pediatric patients treated with high emetic risk antineoplastics who are unable to receive dexamethasone may be approved for generic palonosetron without prior trial and failure of ondansetron/granisetron **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Injectable/Infusible Agents for Osteoporosis and Paget's Disease**
Drugs	Preferred: Forteo (teriparatide) Non-preferred: teriparatide (biosimilar), Tymlos (abaloparatide), Prolia (denosumab), Prolia biosimilars, Evenity (romosozumab), or any other newly marketed agent Other non-formulary: pamidronate, ibandronate (Boniva), zoledronic acid (Reclast)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	"See other criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, rheumatologist, orthopedist, or obstetrician/gynecologist
Coverage Duration	If all of the conditions are met, requests will be approved for 1 year. ***TERIPARATIDE/TYMLOS REQUESTS WILL ONLY BE APPROVED FOR A TOTAL DURATION OF 24 MONTHS*** *** EVENITY WILL ONLY BE APPROVED FOR A TOTAL DURATION OF 12 MONTHS***
Other Criteria	**<u>For all requests:</u>** • Dose is appropriate per labeling or compendia • The member is taking calcium and vitamin D • The member has a documented (consistent with pharmacy claims) adequate trial of an oral bisphosphonate or has a medical reason (e.g. intolerance, hypersensitivity, contraindication, etc.) for not using an oral bisphosphonate • If the request is for Prolia (denosumab) or a Prolia biosimilar, the member has a documented trial and failure with the biosimilar Bildyos (denosumab-nxxp), or a medical reason (e.g. intolerance, contraindication, etc.) as to why the member is unable to use this medication is provided <u>If the diagnosis is postmenopausal or male osteoporosis:</u> • Documentation was submitted indicating member is a postmenopausal woman or a male member over 50 years of age and ONE of the following: o Has a bone mineral density (BMD) value consistent with osteoporosis (T-score equal to or less than –2.5) o Has had an osteoporotic fracture o Has a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability >3% or a 10 year major

	osteoporosis-related fracture probability >20%, based on the US-adapted WHO absolute fracture risk model • If the request is for very high risk postmenopausal osteoporosis or postmenopausal osteoporosis with prior fractures, a documented trial and failure of an oral bisphosphonate is not required o Very high risk is defined as having one or more of the following: ▪ History of fracture in the past 12 months ▪ Multiple fractures ▪ Fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) ▪ Very low T scores (<-3.0) ▪ High risk for falls ▪ History of injurious falls ▪ Very high fracture probability as determined by fracture risk assessment tool (FRAX) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%) • If the request is for Evenity, teriparatide biosimilar, Tymlos, or Prolia, a medical reason why member is unable to use Forteo as appropriate based on diagnosis • If the request is for teriparatide biosimilar, Evenity (romosozumab), or Tymlos (abaloparatide), one of the following applies to the member: o Documented trial and failure of ibandronate (Boniva) or zoledronic acid (Reclast) AND a denosumab biosimilar or has a medical reason (e.g. intolerance, contraindication, etc.) why these therapies are not suitable to be used o Has severe osteoporosis (T-Score -3.5 or below, or T-Score of -2.5 or below plus a fragility fracture) • If the request is for Evenity, the member does not have a history of a heart attack or stroke within the preceding year <u>If the diagnosis is Paget's disease:</u> • Documentation of the following: o Member's serum alkaline phosphatase level of ≥ two times the upper limit of normal (within 60 days of request) o The member is symptomatic OR documentation of biochemically active disease on bone scintigraphy <u>If the diagnosis is glucocorticoid-induced osteoporosis:</u>
Revision/Review Date: 11/2025	• For members ≥ 40 years of age on long-term glucocorticoid therapy: o Documentation that the dosage of the glucocorticoid therapy is greater than 2.5 mg of prednisone daily or its equivalent o Member has a moderate to very high risk of fracture based on ONE of the following: ▪ History of osteoporotic fracture ▪ BMD less than or equal to -1 at the hip or spine ▪ FRAX 10-year probability of hip fracture of > 3 percent ▪ FRAX 10-year risk for combined major osteoporotic fracture greater than 10% percent (with glucocorticoid adjustment)

	• For adult members (all ages) receiving HIGH dose glucocorticoid therapy:
	  ○ Member has a moderate to very high risk of fracture based on ONE of the following:
	  ▪ History of prior fracture
	  ▪ Glucocorticoid dose ≥ 30mg/day or cumulative ≥ 5 grams/year
	  ▪ Continuing glucocorticoid treatment ≥ 7.5mg/day for ≥ 6 months AND BMD Z score < -3 OR significant BMD loss (> least significant change of DXA)
	• If the request is for a teriparatide biosimilar or Tymlos (abaloparatide), the member has a documented trial and failure of zoledronic acid (Reclast) or denosumab biosimilar or a medical reason (e.g. intolerance, contraindication, etc.) as to why the member is unable to use these medications is provided:
	  ○ Requests for teriparatide also require a medical reason why the member is unable to use brand Forteo
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Injectable/Infusible Bone-Modifying Agents for Oncology Indications**
Drugs	pamidronate, zoledronic acid, Xgeva, Prolia, Xgeva biosimilars, Prolia biosimilars, and any newly marketed drug in the class
Covered Uses	The request is for an FDA approved indication or for a medically-accepted indications as defined or as supported by the medical compendia (Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) , Drug Package Insert) as defined in the Social Security Act 1927, or per the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO), or the National Institutes of Health (NIH) Consensus Panel standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 11/2025	**<u>Criteria for Approval:</u>** • The request is for an approved/accepted indication at an approved dose • If the request is for Xgeva (denosumab) or an Xgeva biosimilar, the patient has a documented trial and failure of Bilprevda (denosumab-nxxp), or has a medical reason (intolerance, hypersensitivity, contraindication, renal insufficiency, etc.) for not utilizing this agent to manage their medical condition • If the request is for Prolia (denosumab) or a Prolia biosimilar, the patient has a documented trial and failure of Bildyos (denosumab-nxxp), or has a medical reason (intolerance, hypersensitivity, contraindication, renal insufficiency, etc.) for not utilizing this agent to manage their medical condition • If the request is for Xgeva (denosumab) or an Xgeva biosimilar (denosumab) for any of the indications below, the patient has a documented trial and failure of generic pamidronate OR zoledronic acid that is consistent with claims history, or has a documented medical reason (intolerance, hypersensitivity, contraindication, renal insufficiency, etc) for not utilizing one of these agents to manage their medical condition o Bone metastases from solid tumors o Hypercalcemia of malignancy o Multiple myeloma osteolytic lesions • If the request is for Xgeva (denosumab) or an Xgeva biosimilar (denosumab) for treating Giant cell tumor of bone, documentation has been submitted that the tumor is unresectable, that surgical resection is likely to result in morbidity (e.g. denosumab therapy is being used to aide in the possibility of resection with tumor shrinkage), or that disease has recurred.

	• If the request is for Prolia (denosumab) or a Prolia biosimilar (denosumab) for breast cancer, the patient has a documented trial and failure of generic pamidronate OR zoledronic acid that is consistent with claims history, or has a documented medical reason (intolerance, hypersensitivity, contraindication, renal insufficiency, etc.) for not utilizing one of these agents to manage their medical condition • If the request is for Prolia (denosumab) or a Prolia biosimilar (denosumab) for prostate cancer, approve. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Insulin Pumps**
Drugs	Omnipod Dash Intro Kit, Omnipod Dash Pods, Omnipod 5 G6 Intro kit, Omnipod 5 G6 Pods, Omnipod Go pods **This policy does not apply to pumps reviewed and/or covered by the Medical Benefit including, but not limited to, V-Go 24-hour disposable system and continuous pumps such as MiniMed and t:slim X2. Requests for these products are referred to the plan's Utilization Management team for review.**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	See "Other Criteria"
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 8/2026
	<u>Initial Authorization</u>
	• Diagnosis – diabetes
	• One of the following
	  o Prescribed by or in consultation with an endocrinologist
	  o Member is assisted by a certified diabetes care and education specialists (CDCESs)
	• One of the following
	  o Type 1 diabetes or other insulin-deficient forms of diabetes (e.g. cystic-fibrosis related diabetes)
	• Treatment with multiple daily doses (≥ 3) of insulin
	
	<u>Reauthorization</u>
	• One of the following:
	  o Type 1 diabetes or other insulin-deficient form of diabetes
	  o Prescriber attests member has benefited from, and has continued need for, therapy with an insulin pump
	  o Initial approval was based on continuation of therapy for patient new to plan.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Healthcare professional (HCP) administered/IV Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)**
Drugs	**Non-preferred/non-formulary:** Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab/hyaluronidase-ocsq), Riabni (rituximab-arrx), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase), Lemtrada (alemtuzumab), Tysabri (natalizumab), Tyruko (natalizumab-sztn), Briumvi (ublituximab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Lemtrada: Clinically Isolated Syndrome (CIS), Primary Progressive MS (PPMS) Tysabri, Tyruko, or Briumvi: Primary Progressive MS (PPMS)
Required Medical Information	See "Other Criteria"
Age Restrictions	Patients must be age appropriate per prescribing information, nationally recognized compendia, or peer-reviewed medical literature
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.
Other Criteria	**Initial Authorization** Clinically Isolated Syndrome (CIS), Relapsing Remitting MS (RRMS), Secondary Progressive MS (SPMS) • Diagnosis of CIS, RRMS, or SPMS • The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature • If a non-preferred drug is being requested, the member has had a trial of at least two preferred conventional multiple sclerosis drugs (teriflunomide, Avonex, Betaseron, Copaxone 20 mg, fingolimod, Rebif); or documentation was provided as to why the member cannot use preferred drugs OR For patients with "highly active" MS requesting Lemtrada (alemtuzumab), Tysabri (natalizumab), Tyruko (natalizumab), or rituximab, a trial with one preferred agent will be acceptable. • If the request is for Ocrevus (ocrelizumab), Ocrevus Zunovo, Briumvi, or rituximab, documentation of the following o Attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) o If the request is for a rituximab product other than Ruxience (rituximab), documented medical reason

Revision/Review Date: 05/2026	why the patient cannot use Ruxience (rituximab)
	• If the request is for Tysabri (natalizumab) or Tyruko (natalizumab-sztn), documentation of the following:
	  o Patient does not have a history of progressive multifocal leukoencephalopathy (PML)
	  o Documentation consistent with pharmacy claims data indicating the patient is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications
	• If the request is for Rituxan Hycela (rituximab/hyaluronidase), all of the above AND documented medical reason why the patient cannot use Rituxan (rituximab).
	
	Primary Progressive Multiple Sclerosis (PPMS)
	• Diagnosis of PPMS
	• The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
	• If the request is for Ocrevus (ocrelizumab), Ocrevus Zunovo, or rituximab, documentation of the following has been submitted
	  o Attestation that the patient has been screened for and does not have active HBV
	• If the request is for a rituximab product other than Ruxience (rituximab), documented reason why the patient cannot use Ruxience (rituximab).
	• If the request is for Rituxan Hycela (rituximab/hyaluronidase), all of the above AND documented medical reason why the patient cannot use Rituxan (rituximab).
	
	Reauthorization
	CIS
	• The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
	• Documentation was provided that the prescriber has reviewed the risks and benefits of continuing DMT versus stopping.
	
	RRMS, SPMS, or PPMS
	• Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit)
	• The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
	  o If the request is for Lemtrada (alemtuzumab), documentation that at least 12 months has or will have elapsed since previous treatment
	• If the request is for Tysabri (natalizumab) or Tyruko

	(natalizumab-sztn), documentation of the following has been submitted o Patient does not have a history of PML o Documentation consistent with pharmacy claims data was submitted indicating the patient is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications **<u>Continuation of Therapy Provision:</u>** Members with history of a non-formulary product (within the past 180 days or past 12 months for Lemtrada [alemtuzumab]) are not required to try a preferred agent prior to receiving the non-preferred product. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**HIF-PH Inhibitors for CKD Anemia**
Drugs	Vafseo (vadadustat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Diagnosis of uncontrolled hypertension
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be at least 18 years of age
Prescriber Restrictions	Prescribed by a hematologist or nephrologist
Coverage Duration	If all of the criteria are met, the request will be approved with a 6 month duration.

Other Criteria	**Initial Authorization:**
	• Member has a diagnosis of chronic kidney disease (CKD) and has been undergoing dialysis for minimum time required by FDA labeling.
	• Member has a documented hemoglobin between 8.0 and 11.0 g/dL
	• Member has documentation of trial and failure, intolerance, contraindication, or inability to use erythropoietin stimulating agents (ESA)
	• The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency:
	  o Serum ferritin level (> 100ng/mL)
	  o Transferrin saturation (TSAT) (> 20%)
	• Provider attests that member has no history of myocardial infarction, cerebrovascular event, or acute coronary syndrome in the past 3 months
	• Member will not be receiving concurrent treatment with an ESA
	• Request is for an FDA-approved dose
	• All submitted lab results have been drawn within 30 days of the request
	
	Reauthorization:
	• All submitted lab results have been drawn within 30 days of the reauthorization request.
	• Member has a documented increase in hemoglobin from baseline
	• The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency:
	  o Serum ferritin level (> 100ng/mL)
	  o Transferrin saturation (TSAT) (> 20%)
	• Member will not be receiving concurrent treatment with an ESA
	• Request is for an FDA-approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary

Revision/Review Date: 2/2026	

Field Name	Field Description
Prior Authorization Group Description	**Hypertrophic Cardiomyopathy**
Drugs	Camzyos (mavacamten), Myqorzo (aficamten)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	≥ 18 years
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 5/2026
	<u>Initial Authorization:</u>
	• Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM)
	• Patient has a left ventricular ejection fraction (LVEF) ≥55%
	• Patient has a peak left ventricular outflow tract (LVOT) gradient ≥30 mmHg at rest or with provocation
	• Trial and failure or contraindication to ALL of the following:
	  o Beta blockers (i.e., metoprolol, propranolol, atenolol)
	  o Non-dihydropyridine calcium channel blockers (i.e., verapamil, diltiazem)
	• Prescriber attests that patient is not diagnosed with a disorder that causes cardiac hypertrophy that mimics oHCM (i.e., Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy)
	• For Camzyos, prescriber attests that patient is not using moderate to strong CYP2C19 inducers, strong CYP2C19 inhibitors, or moderate to strong CYP3A4 inducers
	• Medication is prescribed at an FDA approved dose
	
	<u>Re-Authorization:</u>
	• Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class
	• Patient has a left ventricular ejection fraction (LVEF) ≥50% for treatment with Camzyos OR ≥40% for treatment with Myqorzo
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Joenja
Drugs	Joenja (leniolisib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per prescribing information.
Prescriber Restrictions	Prescriber must be an immunologist, hematologist, medical geneticist, or other prescriber who specializes in the treatment of genetic or immunologic disorders.
Coverage Duration	If the criteria are met, requests will be approved with up to a 6-month duration. Thereafter, reauthorization requests will be approved with up to a 12-month duration.
Other Criteria Revision/Review Date 8/2026	**Initial Authorization:** • Documentation of APDS/PASLI-associated PIK3CD/PIK3R1 mutation, confirmed by genetic testing. • Documentation of nodal and/or extranodal lymphoproliferation, history of repeated oto-sino-pulmonary infections and/or organ dysfunction (e.g., lung, liver) • Prescriber attests that the member is not currently taking immunosuppressive medication • Prescriber attests that female patients have been advised of the potential risk to a fetus, will use effective contraception and have had a negative pregnancy test prior to initiation of treatment • Medication is being prescribed at an FDA approved dose **Reauthorization:** • Documentation has been submitted indicating member has experienced a clinical benefit from treatment (e.g., decreased lymph node size, increase in percentage of naïve B cells) • Prescriber attests that female patients will use effective contraception and have had a negative pregnancy test • Medication is being prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Janus Kinase Inhibitors for Nonsegmental Vitiligo**
Drugs	Opzelura (ruxolitinib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI)
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	≥ 12 years of age
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, immunologist, or specialist experienced in treatment of vitiligo
Coverage Duration	If criteria are met, the request will be approved with up to a 6 month duration. All reauthorization requests will be approved up to 12 months in duration.

Other Criteria
 	
Revision/Review Date 11/2025
	Initial Authorization
	o Diagnosis of nonsegmental vitiligo
	o Documentation of depigmented lesions including measurements and locations is provided
	o Prescriber attests that the total body vitiligo area (facial and nonfacial) being treated does not exceed 10% BSA
	o Trial and failure of, or intolerance to, ALL of the following:
	  o Topical corticosteroids
	  o Topical calcineurin inhibitors
	  o Targeted phototherapy
	o Prescriber attests that the member will not concomitantly use therapeutic biologics, other Janus kinase inhibitors, potent immunosuppressants, or phototherapy for repigmentation purposes
	o Request is for an FDA-approved dose
	
	****A MAXIMUM OF ONE 60 GRAM TUBE OF OPZELURA PER WEEK OR ONE 100 GRAM TUBE EVERY TWO WEEKS MAY BE APPROVED****
	
	Reauthorization
	o Prescriber attests that the member has experienced a clinical benefit (e.g., reduction in size or quantity of or stabilization of existing depigmented lesions; absence of new depigmented lesions)
	o Request is for an FDA-approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Agents for Homozygous Familial Hypercholesterolemia (HoFH)**
Drugs	Juxtapid (lomitapide) Evkeeza (evinacumab-dgnb) ****Please refer to the "Proprotein Convertase Subtilisin/kexin 9 (PCSK9) Inhibitors" policy for requests for medications in that class****
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a cardiologist or specialist in the treatment of lipid disorders
Coverage Duration	If all the criteria are met, initial requests will be approved for up to 6 months. Reauthorization requests will be approved for 12 months.

Other Criteria	**Initial Authorization:**
	• Documentation of a diagnosis of homozygous familial hypercholesterolemia (HoFH) via either:
	  o Genetic confirmation of two mutant alleles at the LDL receptor, ApoB, PCSK9 or ARH adaptor protein gene locus; OR
	  o A clinical diagnosis of HoFH which includes: untreated LDL-C >500 mg/dL (>13 mmol/L) or treated LDL-C ≥300 mg/dL (>8 mmol/L), AND
	  ▪ Cutaneous or tendon xanthoma before age 10 years, OR
	  ▪ Elevated LDL-C levels consistent with heterozygous FH in both parents.
	• Request is for an appropriate dose for member according to labeling
	• Documentation of current LDL level was provided
	• Member has tried and failed atorvastatin 40 – 80 mg or rosuvastatin 20 – 40 mg (consistent therapy for 3 months via claim history or chart notes). If member is not able to tolerate atorvastatin or rosuvastatin, documentation was provided that member is taking another statin at the highest tolerated dose, or a medical reason was provided why the member is not able to use these therapies.
	• If prescriber indicates member is "statin intolerant", documentation was provided including description of the side effects, duration of therapy, "wash out", re-trial, and then change of agents.
	• Member has tried and failed ezetimibe at a maximal tolerated dose or a medical reason was provided why the member is not able to tolerate ezetimibe
	• Member has documented trial and failure with a PCSK9 inhibitor for at least 3 months, or a medical reason has been provided why member is unable to use a PCSK9 inhibitor indicated for HoFH to manage the condition.
	• Documentation was provided indicating prescriber has counseled member on smoking cessation and following a "heart healthy diet".

Revision/Review Date: 02/2026	**Re-authorization:** • Documentation submitted (including repeat fasting lipid panel) indicates that the member has obtained clinical benefit from the medication and the member has achieved or maintained LDL reduction from the levels drawn immediately prior to initiation of treatment with Juxtapid or Evkeeza. • The member's claim history shows consistent therapy (monthly fills) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Kebilidi (eladocagene exuparvovec-tneq)**
Drugs	Kebilidi (eladocagene exuparvovec-tneq)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Previous treatment with gene therapy
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a geneticist or neurologist.
Coverage Duration	If all of the criteria are met, the request will be approved for one treatment per lifetime (4 infusions).
Other Criteria Review/Revision Date: 05/2026	• Medication is prescribed at an FDA approved dose • Documentation of genetically confirmed diagnosis of aromatic L-amino acid decarboxylase (AADC) deficiency evidenced by biallelic mutations in the *DDC* gene (copy of genetic test submitted with request) • Documentation of skull maturity confirmed by neuroimaging • Member has classic clinical characteristics (e.g. oculogyric crises, hypotonia, developmental delay) of AADC deficiency that are not well-managed by symptomatic control drugs (i.e. dopamine agonists, monoamine oxidase inhibitor, pyridoxine, etc.) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Kisunla**
Drugs	Kisunla (donanemab-azbt)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patients with moderate to severe Alzheimer's Disease (AD) Patients with neurodegenerative disease caused by a condition other than AD
Required Medical Information	See "Other Criteria"
Age Restrictions	Age 60-85 years
Prescriber Restrictions	Prescribed by a neurologist
Coverage Duration	For initial authorization: if all of the criteria are met, the request will be approved in accordance with the FDA-indicated titration schedule for up to 6 months. For reauthorization: if all of the criteria are met, the request will be approved for 6 months.
Other Criteria	**<u>Initial Authorization</u>** • Diagnosis of mild cognitive impairment (MCI) caused by AD or mild AD dementia consistent with Stage 3 or Stage 4 Alzheimer's disease as evidenced by at least one of the following: o Clinical Dementia Rating Global (CDR-G) score of 0.5-1.0 o Mini-Mental State Examination (MMSE) score ≥ 20 and ≤ 28 o Montreal Cognitive Assessment (MoCA) score of ≥16 • The request is for an FDA approved dose • Documentation of BOTH of the following: o Recent, within past year, positive results for the presence of beta-amyloid plaques on a positron emission tomography (PET) scan or cerebrospinal fluid testing o Recent, within past year, baseline Magnetic Resonance Imaging (MRI) scan • Physician has assessed baseline disease severity utilizing an objective measure/tool (i.e., integrated Alzheimer's Disease Rating Scale [iADRS], Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog], Alzheimer's Disease Cooperative Study-instrumental Activities of Daily Living [ADCS-iADL], Clinical Dementia Rating-Sum of Boxes [CDR-SB], etc.) • No recent (past 1 year) history of stroke, seizures or transient ischemic attack (TIA), or findings on neuroimaging that indicate an increased risk for intracerebral hemorrhage **<u>Reauthorization</u>** • The request is for an FDA approved dose

Revision/Review
Date: 05/2026
	• Member continues to have a diagnosis of MCI caused by AD or mild AD dementia consistent with Stage 3 or Stage 4 Alzheimer's disease as evidenced by at least one of the following:
	  o CDR-G score of 0.5-1.0
	  o MMSE score of 20-28
	  o MoCA score of ≥16
	• Provider attestation of safety monitoring and management of amyloid related imaging abnormalities (ARIA) and intracerebral hemorrhage, as recommended per the manufacturer's prescribing information
	• Documentation that member has experienced clinical benefit from the medication (i.e., stabilization or decreased rate of decline in symptoms from baseline on CDR-SB, iADRS, ADAS-Cog, or ADCS-iADL scales)
	• No recent (past 1 year) history of stroke, seizures or TIA
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Kygevvi**
Drugs	Kygevvi (doxecitine/doxribtimine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist in the treatment of thymidine kinase 2 deficiency (TK2d)
Coverage Duration	If all criteria are met, the initial request will be approved for up to 6 months and reauthorization will be approved for up to 12 months.
Other Criteria Date: 08/2026	**Initial Authorization:** • Documented diagnosis of TK2d confirmed by genetic testing that shows mutations in the TK2 gene • Documentation of initial symptom onset at ≤12 years of age, consistent with infantile- or childhood-onset TK2d • Prescriber attests to obtaining baseline liver transaminase (ALT, AST) and total bilirubin levels prior to initiation of treatment • Medication is prescribed at an FDA approved dose **Reauthorization:** • Documentation of positive clinical benefit (i.e., stabilization or improvement in motor function, respiratory function, or other clinical symptoms) • Prescriber attests to monitoring liver transaminase (ALT, AST) and total bilirubin levels • Medication is prescribed at an FDA approved dose **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Prior Authorization Group Description	**Lenmeldy (atidarsagene autotemcel)**
Drugs	Lenmeldy (atidarsagene autotemcel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a hematologist/oncologist, neurologist, or geneticist
Coverage Duration	If all the criteria are met, the request will be approved for a one-time treatment.

Other Criteria
 	
Review/Revision Date: 5/2026
	• Member has diagnosis of one of the following metachromatic leukodystrophies (MLD):
	  o Pre-symptomatic late infantile (PSLI) MLD
	  o Pre-symptomatic early juvenile (PSEJ) MLD
	  o Early symptomatic early juvenile (ESEJ) MLD
	• Documentation patient has both of the following:
	  o Arylsulfatase A (ARSA) activity below the normal range (normal range 31-198 nmol/mg/h)
	  o Identification of two disease-causing ARSA alleles
	• Medication is prescribed at an FDA approved dose
	
	The safety and effectiveness of repeat administration of Lenmeldy has not been evaluated and will not be approved.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Leqembi (lecanemab-irmb)**
Drugs	Leqembi (lecanemab-irmb) intravenous Leqembi IQLIK (lecanemab-irmb) subcutaneous injection
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patients with moderate to severe Alzheimer's Disease (AD) Patients with neurodegenerative disease caused by a condition other than AD
Required Medical Information	See "Other Criteria"
Age Restrictions	50-90 years old
Prescriber Restrictions	Prescribed by a neurologist
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months.
Other Criteria	**Initial Authorization** • Diagnosis of mild cognitive impairment (MCI) caused by AD or mild AD consistent with Stage 3 or Stage 4 Alzheimer's disease as evidenced by at least one of the following: o Clinical Dementia Rating Global (CDR-G) score of 0.5-1.0 and a Memory Box score of 0.5 or greater o Mini-Mental State Examination (MMSE) score ≥ 22 and ≤ 30 o Wechsler Memory Scale IV-Logical Memory (subscale) II (WMS-IV LMII) score at least 1 standard deviation below age-adjusted mean • The request is for an FDA approved dose • Documentation of BOTH of the following: o Recent, within past year, positive results for the presence of beta-amyloid plaques on a positron emission tomography (PET) scan or cerebrospinal fluid testing o Recent, within past year, baseline Magnetic Resonance Imaging (MRI) scan • Physician has assessed baseline disease severity utilizing an objective measure/tool (i.e., Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-14], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating Sum of Boxes [CDR-SB], etc.) • No recent (past 1 year) history of stroke, seizures or transient ischemic attack (TIA), or findings on neuroimaging that indicate an increased risk for intracerebral hemorrhage. • If request is for Leqembi IQLIK, patient meets all the above requirements and has been established on intravenous Leqembi for at least 18 months **Reauthorization**

Revision/Review
Date: 05/2026
	• The request is for an FDA approved dose
	• Patient continues to have a diagnosis of mild cognitive impairment (MCI) caused by AD or mild AD consistent with Stage 3 or Stage 4 Alzheimer's disease as evidenced by at least one of the following:
	  o CDR-G score of 0.5-1.0 and a Memory Box score of 0.5 or greater
	  o MMSE score of 22-30
	  o Wechsler Memory Scale IV-Logical Memory (subscale) II (WMS-IV LMII) score at least 1 standard deviation below age-adjusted mean
	• Provider attestation of safety monitoring and management of amyloid related imaging abnormalities (ARIA) and intracerebral hemorrhage, as recommended per the manufacturer's prescribing information.
	• Documentation that member has experienced clinical benefit from the medication (such as: stabilization or decreased rate of decline in symptoms from baseline on CDR-SB, ADAS-Cog14, or ADCS MCI-ADL scales)
	• No recent (past 1 year) history of stroke, seizures, or TIA
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Lidocaine patch**
Drugs	lidocaine (Lidoderm) 5% patch Ztlido (lidocaine) 1.8% patch
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Per package insert
Prescriber Restrictions	N/A
Coverage Duration	If the conditions are met, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 8/2026	The member has a diagnosis of postherpetic neuralgia OR The member has an alternate diagnosis AND Documented trial and failure of (or documented medical reason for not using) ALL of the following: • Non-steroidal anti-inflammatory drug (NSAID) • Tri-cyclic antidepressant • Gabapentin or pregabalin **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Loargys (pegzilarginase-nbln)**
Drugs	Loargys (pegzilarginase-nbln)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or specialist experienced in Urea Cycle Disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review
Date: 05/2026
	<u>Initial Authorization:</u>
	
	• Medication is prescribed at an FDA approved dose
	• Documentation of patient weight
	• Diagnosis of Arginase 1 Deficiency (ARG1-D) confirmed by one of the following:
	  o Pathogenic variants in ARG1 (copy of genetic results must be submitted with request)
	  o Elevated plasma arginine (pArg)
	  o Diminished erythrocyte ARG1 activity
	• Provider attestation member will use the drug in conjunction with a protein restricted diet
	• Documentation of baseline pArg
	
	<u>Re-Authorization:</u>
	
	• Documentation of positive clinical response as evidenced by normalization in pArg
	• Documentation of member's weight
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Lodoco (colchicine)
Drugs	Lodoco (colchicine) tablets
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA approved prescribing information
Prescriber Restrictions	Prescribed by or in consultation with a specialist in the treatment of cardiovascular disease, such as a cardiologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Review/Revision Date: 11/2025
	• Patient has established atherosclerotic disease or multiple risk factors for cardiovascular disease
	• Patient is currently receiving statin therapy, or documentation has been provided that the member has a medical reason statin therapy is not appropriate
	• Documentation is provided that guideline directed medical therapies targeted to patient's specific risk factors are being maximized, such as medications targeted at reduction in cholesterol, blood pressure, antiplatelet therapies, and diabetes
	• Patient does not have pre-existing blood dyscrasias (ex. leukopenia, thrombocytopenia)
	• Patient does not have renal failure (CrCl less than 15 ml/min) or severe hepatic impairment
	• Patient is not currently taking medications contraindicated for concurrent use with Lodoco
	  ○ Strong CYP3A4 inhibitors (ex. atazanavir, clarithromycin, darunavir/ritonavir, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, tipranavir/ritonavir)
	  ○ P-glycoprotein inhibitors (ex. cyclosporine, ranolazine)
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	Luxturna (voretigene neparvovec-rzyl)
Drugs	Luxturna (voretigene neparvovec-rzyl)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Intraocular surgery within the past 6 months
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for a one-time dose per eye.
Other Criteria Review/Revision Date: 05/2026	• Medication is prescribed at an FDA approved dose • Diagnosis of confirmed biallelic RPE65 mutation-associated retinal dystrophy (e.g., Leber congenital amaurosis (LCA), retinitis pigmentosa (RP), early-onset severe retinal dystrophy (EOSRD), etc.) • Member has viable retinal cells as determined by non-invasive means, such as optical coherence tomography (OCT) and/or ophthalmoscopy indicating one or more of the following: o An area of retina within the posterior pole of >100 μm thickness shown on OCT o ≥ 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole o Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent • Member has significant vision loss determined by one of the following: o Visual acuity of 20/60 or worse in both eyes o Visual field less than 20 degrees in any meridian **The safety and effectiveness of repeat administration of Luxturna have not been evaluated and will not be approved.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**MEK Inhibitors for Neurofibromatosis Type 1 (NF1)**
Drugs	Gomekli (mirdametinib), Koselugo (selumetinib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Prior use of a MEK inhibitor
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Review/Revision Date: 05/2026	**<u>Initial Authorization:</u>** • Documentation of neurofibromatosis type 1 (NF1) with symptomatic plexiform neurofibromas (PN) not amenable to complete resection • Drug will be given as monotherapy • Medication is prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e. no evidence of progressive disease) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Mucopolysaccharidosis II (Hunter Syndrome) Agents**
Drugs	Avlayah (tividenofusp alfa-eknm) Elaprase (idursulfase) Any other marketed agent within the class
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Concomitant use of Elaprase and Avlayah
Required Medical Information	"See Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a specialist experienced in the management of Mucopolysaccharidosis II (geneticist, endocrinologist, neurologist, rheumatologist, etc)
Coverage Duration	If all of the criteria are met, requests will be approved for up to 12 months.

Other Criteria	**<u>Initial Authorization</u>**
	• Diagnosis of Mucopolysaccharidosis II as confirmed by one of the following:
	  o Enzyme assay demonstrating a deficiency of iduronate 2-sulfatase activity
	  o Genetic testing
	• Member's weight
	• Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines
	• Requests for Avlayah also require all of the following:
	  o Documentation of neurologic manifestations associated with Mucopolysaccharidosis II OR patient is presymptomatic and at risk for neurologic manifestations
	  o Documentation that patient does not have advanced neurologic impairment
	
	<u>Reauthorization</u>
	• Member has demonstrated a beneficial response (i.e., stabilization or improvement in cerebrospinal fluid (CSF) or urine heparan sulfate (HS), neurologic or functional status, 6-minute walk test [6-MWT], forced vital capacity [FVC]), urinary glycosaminoglycan (GAG) levels, liver volume, spleen volume, etc.)
	• Member's weight
	• Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines

Revision/Review Date 08/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Mucopolysaccharidosis VII (MPS VII, Sly syndrome)
Drugs	Mepsevii (vestronidase alfa-vjbk)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Central nervous system manifestations of mucopolysaccharidosis VII
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a geneticist, metabolic specialist, or a physician who specializes in the treatment of lysosomal storage disorders.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 12 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria
 	
Date: 11/2025
	Initial Authorization:
	• Medication is prescribed at an FDA approved dose
	• Confirmed diagnosis of MPS VII/Sly syndrome based on leukocyte or fibroblast glucuronidase enzyme assay or genetic testing
	• Documentation of elevated urinary glycosaminoglycan (uGAG) excretion at a minimum of 3-fold over the mean normal for age
	• Documentation of baseline values for at least ONE of the following:
	  o uGAG
	  o Age-appropriate motor function, visual acuity, and/or 6-minute walk test (6-MWT)
	  o Age-appropriate pulmonary function tests (e.g. predicted forced vital capacity (FVC))
	• Prescriber attestation that Mepsevii will be used as monotherapy
	
	Re-Authorization:
	• Medication is prescribed at an FDA approved dose
	• Documentation or provider attestation of positive clinical response (i.e. reduction in urinary excretion of uGAG, improvement in FVC, etc.)
	• Prescriber attestation that Mepsevii will be used as monotherapy
	• Prescriber attestation of the absence of severe adverse events
	
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Prior Authorization Group Description	**Multaq**
Drugs	**Multaq (dronedarone)**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Permanent atrial fibrillation
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is a cardiologist or electrophysiologist
Coverage Duration	If the criteria are met, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 2/2026	Criteria for Approval: • Documented diagnosis of paroxysmal or persistent atrial fibrillation or atrial flutter • Attestation that the patient does not have NYHA Class III or IV heart failure • Attestation that the patient has not had an episode of decompensated heart failure in the last 4 weeks **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Myasthenia Gravis Agents
Drugs	Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase), Rystiggo (rozanolixizumab), Soliris (eculizumab), Ultomiris (ravulizumab), Zilbrysq (zilucoplan), BVEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh), Imaavy (nipocalimab-aahu)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or rheumatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • For diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy, refer to the "Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents" policy • Diagnosis of generalized myasthenia gravis (gMG) • Patient has a positive serological test for one of the following: o Anti-AChR antibodies o Anti-muscle-specific tyrosine kinase (MuSK) antibodies (Rystiggo and Imaavy) • Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II, III or IV • For adults: patient has tried and failed, or has contraindication, to one of the following: o At least 1 conventional therapy (i.e., acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies) o Requires chronic plasmapheresis or plasma exchange or intravenous immunoglobulin to control symptoms • Medication is prescribed at an FDA approved dose • Patient is not using agents covered by this policy concurrently (i.e., no concurrent use of Vyvgart, Vyvgart Hytrulo, Rystiggo, Soliris, Ultomiris, BKEMV, Epysqli, or Zilbrysq) • Requests for Imaavy, Soliris (eculizumab), Ultomiris (ravulizumab), BKEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh), and Zilbrysq (zilucoplan) will also require the following: o All ages: documentation patient complies with the most current

Revision/Review Date: 05/2026	Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal infections in patients receiving a complement inhibitor. ○ **<u>Re-Authorization:</u>** • Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality-of-life scores, MG-ADL scores, etc). • Medication is prescribed at an FDA approved dose. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Parsabiv**
Drugs	Parsabiv (eteclacetide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	If all criteria are met, the request will be approved for a duration of 12 months.
Other Criteria	Initial: • Confirmed diagnosis of secondary hyperparathyroidism with chronic kidney disease (CKD) • Member is on hemodialysis • Documentation that member's corrected calcium is at or above the lower limit of normal • Documentation of trial and failure, contraindication or intolerance to cinacalcet • Member is on stable doses of active vitamin D analogs or calcium supplements or phosphate binders • Member is not receiving Parsabiv in combination with cinacalcet • Request is for an FDA approved dose Reauthorization: • Documentation that member is responding to therapy and experiencing a clinical benefit (i.e., noticeable reduction in PTH levels) • Member is not receiving Parsabiv with cinacalcet • Request is for an FDA approved dose
Revision/Review Date: 11/2025	**Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Pompe Disease Agents
Drugs	Nexviazyme (avalglucosidase alfa-ngpt) injection Lumizyme (alglucosidase alfa) Pombiliti (cipaglucosidase alfa-atga) + Opfolda (miglustat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a specialist in the treatment of Pompe disease, such as a genetic or metabolic specialist, neurologist, cardiologist, or pediatrician.
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Review/Revision Date: 02/2026
	Initial Authorization:
	For infantile onset Pompe Disease (Lumizyme only):
	• Patient has a diagnosis of infantile-onset Pompe Disease, confirmed by one of the following:
	  o Enzyme assay showing a deficiency of acid alpha-glucosidase (GAA) activity in the blood, skin, or muscle
	  o Genetic testing showing a mutation in the GAA gene
	• Requested dose is appropriate per prescribing information (documentation of patient weight must be submitted with request)
	• Requested regimen will not be used in combination with other enzyme replacement therapies
	
	For late onset Pompe Disease (Lumizyme, Nexviazyme, or Pombiliti + Opfolda):
	• Patient has a diagnosis of late-onset (non-infantile) a diagnosis of Pompe Disease, confirmed by one of the following:
	  o Enzyme assay showing a deficiency of acid alpha-glucosidase (GAA) activity in the blood, skin, or muscle
	  o Genetic testing showing a mutation in the GAA gene
	• Documentation is submitted confirming a diagnosis of late-onset (non-infantile) Pompe disease
	• Requested regimen will not be used in combination with other enzyme replacement therapies (exception: Pombiliti + Opfolda are to be used together)
	• Requested dose is appropriate per prescribing information (documentation of patient weight must be submitted with request)
	
	Re-Authorization:
	• Documentation or provider attestation of positive clinical response to therapy

	○ Infantile onset: provider attestation of member benefit ○ Late onset: improvement, stabilization, or slowing of progression of percent-predicted FVC and/or 6MWT • Requested dose is appropriate per prescribing information (documentation of patient weight must be submitted with request) • Requested regimen will not be used in combination with other enzyme replacement therapies (exception: Pombiliti + Opfolda are to be used together) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Pulmonary Biologics for Respiratory and Eosinophilic Conditions**
Drugs	Preferred: • Dupixent • Nucala (mepolizumab) Non-Preferred: • Fasenra (benralizumab) • Cinqair (reslizumab) • Tezspire (tezepelumab) • Exdensur (depemokimab) • or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• When being used for relief of acute bronchospasm or status asthmaticus • When used in combination with another monoclonal antibody for the treatment of respiratory or eosinophilic conditions
Required Medical Information	See "other criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be an allergist, immunologist, pulmonologist, dermatologist, gastroenterologist, or rheumatologist; or is a provider working in consultation with one of these specialists
Coverage Duration	The initial request will be approved for 6 months. All subsequent requests will be approved for 12 months.

Other Criteria	**Initial Authorization:**
	
	Asthma:
	• Confirmed diagnosis of one of the following:
	  o Nucala, Fasenra, Exdensur, Cinqair: severe eosinophilic asthma
	  o Dupixent: moderate to severe eosinophilic asthma
	  o Tezspire: severe asthma
	• The prescribed dose is within FDA approved dosing guidelines
	• Documentation has been provided of blood eosinophil counts within one of the following ranges:
	
	  o Nucala and Exdensur: ≥150 cells/mcL (within 6 weeks of request) OR ≥300 cells/mcL (within the past 12 months)

	○ Dupixent and Fasenra: ≥150 cells/mcL (within the past 12 months) ○ Cinqair: ≥ 400 cells/mcL (within the past 12 months) ○ Tezspire: No baseline eosinophil counts are required • The member has a documented baseline forced expiratory volume in one second (FEV_1) < 80% of predicted with evidence of reversibility by bronchodilator response. ○ If age is <18 years, the member has a documented baseline FEV1 < 90% of predicted with evidence of reversibility by bronchodilator response. • Documentation has been provided indicating that the member continues to experience significant symptoms while compliant on a maximally-tolerated inhaled corticosteroid with a long-acting $Beta_2$ agonist (ICS/LABA) AND a long-acting muscarinic antagonist (LAMA) (or a documented medical reason must be provided why the member is unable to use these therapies • The member has experienced the one of the following: ○ Fasenra: ≥ 2 exacerbation in the previous 12 months ○ Cinqair: ≥1 exacerbation in the past 12 months requiring systemic corticosteroids ○ Exdensur: ≥ 2 exacerbations in the previous 12 months requiring systemic corticosteroids ○ Dupixent: ≥1 exacerbation in the past 12 months requiring systemic corticosteroids or hospitalization ○ Tezspire: ≥2 exacerbations requiring systemic corticosteroids OR ≥1 exacerbation in the past 12 months requiring hospitalization ○ Nucala: ≥ 2 exacerbations in the previous 12 months • If the request if for Fasenra or Cinqair, the member has a documented trial and failure of Dupixent or Nucala or a medical reason why Dupixent or Nucala cannot be used <u>Chronic Obstructive Pulmonary Disease (COPD) *(Dupixent and Nucala only)*</u>: • Confirmed diagnosis of COPD • Documentation has been provided of blood eosinophil count within one of the following ranges: ○ Dupixent: ≥ 300 cells/mcL (within past 12 months) ○ Nucala: ≥ 150 cells/mcL (within 6 weeks of request) OR ≥ 300 cells/mcL (within past 12 months) • The member has a documented post-bronchodilator FEV_1/FVC ratio < 0.7 and post-bronchodilator FEV_1 of 20% to 80% predicted • Documentation has been provided indicating that that the member continues to experience significant symptoms (i.e., chronic productive cough) while compliant on maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta2 agonist (LABA), and inhaled corticosteroid (ICS) (or a documented medical reason must be provided why the member is unable to use these therapies) and ONE of the following: ○ ≥ 2 exacerbations in the past 12 months, where systemic corticosteroids were required for at least one of them

Revision/Review Date: 11/2026	○ ≥ 1 exacerbation in the past 12 months requiring hospitalization • The prescribed dose is within FDA approved dosing guidelines • If the request if for a non-preferred agent, the member has a documented trial and failure of Dupixent or Nucala or a medical reason why Dupixent or Nucala cannot be used <u>Oral Corticosteroid Dependent Asthma: (Dupixent only)</u> • Confirmed diagnosis of oral corticosteroid (OCS) dependent asthma with at least 5 mg oral prednisone or equivalent per day for at least 4 weeks within the last 3 months • The member has a documented baseline FEV1 < 80% of predicted with evidence of reversibility by bronchodilator response. • Documentation has been provided indicating patient is still having significant symptoms with ≥ 1 exacerbation in the previous 12 months requiring additional medical treatment (emergency room visits, hospital admissions) while compliant on a high-dose inhaled corticosteroid with a long-acting B2 agonist (ICS/LABA) AND a long-acting muscarinic antagonist (LAMA). If the patient has not utilized these therapies, a documented medical reason must be provided why patient is unable to do so. • The prescribed dose is within FDA approved dosing guidelines <u>Eosinophilic Esophagitis (EoE) *(Dupixent only):*</u> • Confirmed diagnosis of EoE by endoscopic biopsy • Documentation of baseline esophageal intraepithelial eosinophil count and Dysphagia Symptom Questionnaire (DSQ) scores • Member has a history of at least 2 episodes of dysphagia (with intakes of solids) per week in the last 4 weeks • Documented trial and failure, intolerance, or contraindication to one proton pump inhibitor at a maximally tolerated dose for a minimum of 8 weeks • The prescribed dose is within FDA approved dosing guidelines <u>Prurigo Nodularis (PN) (*Dupixent only):*</u> • Confirmed diagnosis of PN lasting for at least three months prior to request • Member has a Worst-itch Numeric Rating Scale (WI-NRS) score of 7 or higher indicating severe or very severe itching • Member has at least 20 PN lesions in total • Documented trial and failure, intolerance, or contraindication to at least two of the following for a minimum of two weeks: ○ One medium to super-high potency topical corticosteroid ○ One topical calcineurin inhibitor ○ UVB phototherapy or psoralen plus UVA phototherapy • The prescribed dose is within FDA approved dosing guidelines <u>Chronic Spontaneous Urticaria (CSU) (*Dupixent only):*</u> • Confirmed diagnosis of CSU • Documented history of urticaria for at least 6 weeks • Member remains symptomatic despite a minimum two week trial of a formulary second generation H1 antihistamine at the maximum tolerated dose; or has a medical reason for not utilizing a second generation antihistamine

	• The prescribed dose is within FDA approved dosing guidelines
	
	<u>Bullous Pemphigoid (*Dupixent only):*</u>
	• Confirmed diagnosis of bullous pemphigoid
	• Member has a Bullous Pemphigoid Disease Area Index (BPDAI) activity score ≥24
	• Member has a Peak Pruritus Numeric Rating Scale (NRS) score ≥4
	• Documented trial and failure, intolerance, or contraindication to at least three of the following:
	  o High potency topical corticosteroids
	  o Oral corticosteroids
	  o Doxycycline
	  o Immunosuppressive therapies (ex. azathioprine, mycophenolate, methotrexate, etc.)
	• The prescribed dose is within FDA approved dosing guidelines
	
	<u>Eosinophilic granulomatosis with polyangiitis (EGPA) (*Fasenra & Nucala only*):</u>
	• Confirmed diagnosis of EGPA and eosinophilic asthma lasting for ≥ 6 months
	• Member has a history of relapsing disease defined as at least one EGPA relapse requiring additional corticosteroids or immunosuppressant or hospitalization within the past 2 years OR member has a history of refractory disease defined as failure to attain remission in the prior 6 months following induction treatment with standard therapy
	• Member must be on a stable dose of oral corticosteroids for at least 4 weeks prior to request
	• Member has a blood eosinophil count ≥1,000 cells/mcL OR > 10% of total leukocyte count
	• Documented trial and failure, intolerance, or contraindication to one of the following: cyclophosphamide, rituximab, azathioprine, methotrexate., or mycophenolate mofetil.
	• The prescribed dose is within FDA approved dosing guidelines
	• If the request is for Fasenra, member must also have a documented trial and failure, intolerance, or contraindication to Nucala
	
	<u>Hypereosinophilic Syndrome (HES) (*Nucala only*):</u>
	• Confirmed diagnosis of FIP1 like 1-platelet derived growth factor receptor alpha-negative HES lasting for ≥6 months without an identifiable non-hematologic secondary cause
	• Member has a history of two or more HES flares (worsening of HES-related symptoms necessitating therapy escalation or ≥2 courses of rescue oral corticosteroids) within the past 12 months
	• Member has a blood eosinophil count ≥1,000 cells/mcL
	• Documented trial and failure, intolerance, or contraindication to oral corticosteroids AND at least one second-line agent (e.g. hydroxyurea,

	interferon, imatinib, methotrexate, cyclophosphamide, cyclosporine, azathioprine) (member must be on stable dose of at least one agent for at least 4 weeks prior to request) **<u>Re-Authorization:</u>** • Documentation submitted indicates the member has experienced a clinical benefit from the medication (e.g. Asthma and COPD: improved FEV1, reduced exacerbations; HES: symptomatic improvement, reduced oral corticosteroid dose; EGPA: reduction in relapse frequency or severity, disease remission, symptomatic improvement, reduced oral corticosteroid dose; EoE: histological remission, improvement in DSQ scores; PN: improvement in WI-NRS score, symptomatic improvement; CSU: decrease in severe itching or urticaria activity; bullous pemphigoid: sustained remission, improvement in Peak Pruritus NRS score) • The prescribed dose is within FDA-approved dosing guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Presbyopia Agents**
Drugs	Vuity (pilocarpine HCl ophthalmic solution)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Vuity: 40-55 years
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Diagnosis of presbyopia • Trial and failure or contraindication to corrective lenses (i.e., eye glasses, contact lenses) • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response • Medication is prescribed at an FDA approved dose
Review/Revision Date: 2/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Primary Hyperoxaluria Agents**
Drugs	Oxlumo (lumasiran) Rivfloza (nedosiran)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to Package Insert
Prescriber Restrictions	Prescribed must by or in consultation with a nephrologist, urologist, hepatologist, endocrinologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 2/2026
	Initial Authorization
	• Diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by evidence of elevated urinary oxalate excretion and one of the following:
	  o Genetic testing confirming at least one mutation at the AGXT gene
	  o Liver biopsy demonstrating absent or significantly reduced AGT activity
	• Metabolic testing demonstrating the following:
	  o For Oxlumo (one of the following):
	  ▪ Increased urinary oxalate excretion (≥ 0.5 mmol/1.73 m2 per day[45 mg/1.73 m2 per day])
	  ▪ Increased urinary oxalate:creatinine ratio relative to normative values for age
	  ▪ Increased plasma oxalate level (≥ 20 µmol/L)
	  o For Rivfloza (one of the following):
	  ▪ Increased urinary oxalate excretion (≥ 0.5 mmol/1.73 m2 per day[45 mg/1.73 m2 per day])
	  ▪ Increased urinary oxalate:creatinine ratio relative to normative values for age
	• For Rivfloza: member has relatively preserved kidney function (e.g., EGFR ≥ 30 mL/min/1.73 m2)
	• Member is concurrently using pyridoxine or has tried and failed previous pyridoxine therapy for at least 3 months, or has a medical reason for not using pyridoxine
	• Member has no history of liver transplant
	• Medication is prescribed at an FDA approved dose
	• Patient is not using Oxlumo and Rivfloza concurrently
	
	Reauthorization
	• Members previously using pyridoxine will continue to use pyridoxine, or have a medical reason for not using pyridoxine
	• Documentation has been provided that demonstrates a clinical benefit (e.g. symptomatic improvement, reduction in urinary oxalate, urinary oxalate:creatinine ratio, or plasma oxalate levels from baseline)

	• Medication is prescribed at an FDA approved dose • Patient is not using Oxlumo and Rivfloza concurrently **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Natriuretic Peptides for Achondroplasia**
Drugs	Voxzogo (vosoritide) Yuviwel (navepegritide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Hypochondroplasia or short stature condition other than achondroplasia
Required Medical Information	See "Other Criteria"
Age Restrictions	According to FDA approved prescribing information
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, medical geneticist, or other specialist for the treatment of achondroplasia
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 8/2026	**<u>Initial Authorization:</u>** • Member has a diagnosis of achondroplasia as confirmed via genetic testing • Prescriber attests patient has open epiphyses: • Documentation of baseline growth velocity • Medication is prescribed at an FDA approved dose • If the request is for Yuviwel, member must have had inadequate response to, or medical reason why patient cannot use Voxzogo **<u>Re-Authorization:</u>** • Documentation of positive clinical response to therapy (as demonstrated by improvement over baseline in annualized growth velocity) • Prescriber attests patient has open epiphyses • Medication is prescribed at an FDA approved dose **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Prior Authorization Group Description	**Nemluvio (nemolizumab-ilto)**
Drugs	Nemluvio (nemolizumab-ilto)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescriber must be an allergist, immunologist, or a dermatologist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Review Date: 02/2026
	<u>Initial Authorization:</u>
	• Diagnosis of severe prurigo nodularis (PN) with ≥ 6 weeks of pruritus
	• Member has ≥ 20 PN lesions
	• Documentation of member's weight
	• Member has a ≥ 2-week trial of one of the following:
	  o Moderate potency or higher topical corticosteroid (TCS)
	  o Topical calcineurin inhibitor (TCI)
	• Medication is prescribed at an FDA approved dose
	
	<u>Re-Authorization:</u>
	• Documentation or provider attestation of positive clinical response (reduced nodular lesion count, decreased pruritis, etc.)
	• Documentation of member's weight
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Niemann-Pick Disease Type C**
Drugs	Aqneursa (levacetylleucine) Miplyffa (arimoclomol)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Concomitant use of Miplyffa and Aqneursa
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a neurologist, geneticist, or specialist in the treatment of Niemann-Pick disease type C (NPC)
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 02/2026
	<u>Initial Authorization</u>
	• Diagnosis of NPC as confirmed by genetic testing demonstrating one of the following:
	  o Mutations in both alleles of NPC1 gene or NPC2 gene
	  o Mutation in one allele of NPC1 or NPC2 AND either a positive filipin-staining or elevated cholestane triol/oxysterols (>2x the upper limit of normal)
	• Documentation that member has at least one neurological sign of NPC (i.e., cognitive decline, vertical supranuclear gaze palsy, ataxia, seizures, etc.)
	• Documentation that member is ambulatory
	• For Miplyffa, prescriber must also attest that member will use in combination with miglustat
	• Member's weight
	• Request is for an FDA-approved dose
	
	<u>Reauthorization</u>
	• Documentation of positive clinical response to therapy (i.e., improvement or stabilization in ambulation, fine motor skills, swallowing, or speech)
	• Member's weight
	• Request is for an FDA-approved dose
	
	Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Nitisinone Products**
Drugs	Nitisinone (Orfadin) capsules Orfadin suspension Nityr (nitisinone) tablets Harliku (nitisinone) tablets
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a specialist in the diagnosis submitted
Coverage Duration	If all criteria are met, initial requests will be approved for up to 6 months and reauthorization requests will be approved for up to 12 months.

Other Criteria	**Initial Authorization for alkaptonuria (AKU) (Harliku and generic nitisinone only)**
	• Diagnosis of AKU confirmed by one of the following:
	  o Urinary homogentisic acid (HGA) excretion of >0.4 g/24 hours
	  o Genetic testing reveals variations in the homogentisate 1,2 dioxygenase (HGD) gene
	• Documented clinical manifestation of AKU (e.g. urine that darkens when exposed to air, ochronosis, chronic joint pain)
	• For Harliku, documented trial and failure, or intolerance to treatment with generic nitisinone prescribed at a dose for the treatment of AKU
	• For Harliku, the drug is prescribed at an FDA approved dose
	
	Initial Authorization for Hereditary Tyrosinemia Type 1 (all nitisinone products EXCEPT Harliku):
	• Diagnosis of Hereditary Tyrosinemia Type 1 confirmed by one of the following:
	  o DNA testing
	  o Detection of succinylacetone (SA) in urine or blood test
	• Documentation provided attesting to diet restricting tyrosine and phenylalanine

Revision/Review Date: 11/2025	• If request is for Nityr tablet or Orfadin suspension, documentation of trial and failure, intolerance, contraindication, or inability (i.e., drug interaction, allergy, adverse reaction, etc.) to use generic nitisinone (Orfadin) capsule • Drug is prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • Attestation that member is achieving a clinical benefit from treatment o For Harliku, clinical benefit evidenced by decrease in urinary homogentisic acid [HGA] levels, decrease in visible ochronosis, and/or improvement/stabilization in joint-related symptoms • Medication is prescribed at an FDA approved dose **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Prior Authorization Group Description	**Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents**
Drugs	Step 1: Rituximab (Rituxan, Truxima, Ruxience, Riabni) Enspryng (satralizumab-mwge) Uplizna (inebilizumab-cdon) Step 2: Soliris (eculizumab) Ultomiris (ravulizumab-cwvz)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	For Enspryng, Uplizna, Soliris, Ultomiris: Anti-aquaporin-4 (AQP4) antibody **negative** neuromyelitis optica spectrum disorder (NMOSD)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a specialist who is experienced in the treatment of NMOSD (such as immunologist, neurologist or hematologist)
Coverage Duration	If all of the criteria are met, requests will be approved for 12 months.
Other Criteria	**Initial Authorization:** For rituximab (Rituxan, Truxima, Ruxience, Riabni): • Member has a diagnosis of NMOSD • Documentation indicating that the patient has been screened for hepatitis B virus (HBV) prior to initiation of treatment • Dosing is supported by compendia or standard of care guidelines • If the request is for a rituximab product other than Ruxience (rituximab-pvvr) or Riabni (rituximab-arrx), there is a documented trial and failure of Ruxience (rituximab-pvvr) or Riabni (rituximab-arrx), or a medical reason why (e.g. intolerance, hypersensitivity, contraindication) they cannot be used For Enspryng or Uplizna: • Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody **positive** NMOSD • Provider attests to completion of the following assessments prior to the first dose as outlined in the prescribing information: o Hepatitis B virus screening o Tuberculosis screening o Patient has not received live or attenuated-live virus vaccines within 4 weeks before the start of therapy o Liver transaminase screening (Enspryng only) o Quantitative serum immunoglobulins (Uplizna only)

Revision/Review Date: 11/2025	• Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines <u>For Soliris or Ultomiris:</u> • Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody **positive** NMOSD • Documentation patient complies with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria • Antimicrobial prophylaxis with oral antibiotics (such as penicillin, macrolides, etc.) for two weeks if the meningococcal vaccine is administered less than two weeks before starting therapy, or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis • Documented trial and failure or medical reason (e.g., intolerance, hypersensitivity, contraindication) why member cannot use TWO of the following: o Rituximab, azathioprine, or mycophenolate mofetil o Enspryng o Uplizna • Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines **<u>Reauthorization:</u>** • Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit) • Request is for an FDA approved/medically accepted dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Ohtuvayre (ensifentrine)**
Drugs	Ohtuvayre (ensifentrine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Primary diagnosis of asthma • Concomitant use of oral PDE4 inhibitors
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Ohtuvayre must be prescribed by or in consultation with a pulmonologist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for a 6 month duration and reauthorization requests will be approved for up to a 12 month duration.
Other Criteria Review/Revision Date: 11/2025	**<u>Initial Authorization:</u>** • Diagnosis of chronic obstructive pulmonary disease (COPD) • Documentation of a pre- and post-albuterol FEV1/FVC ratio of <0.70 • Documentation of a score of ≥ 2 on the Modified Medical Research Council (mMRC) Dyspnea Scale or a score of ≥ 10 on the COPD Assessment Test (CAT) • Documented trial, intolerance, or contraindication to treatment with a long-acting beta-2 agonist (LABA) plus a long-acting muscarinic antagonist (LAMA) (or a documented medical reason must be provided why the member is unable to use these therapies)The drug is being prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • The drug is being prescribed at an FDA approved dose • Documentation of clinical benefit from the medication (e.g., improvement in symptoms and exacerbations, improvement in mMRC or CAT, improvement in FEV1/FVC ratio, etc.) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Omisirge**
Drugs	**Omisirge (omidubicel-onlv)**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patient has previously received this medication
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, or transplant specialist
Coverage Duration	If all the criteria are met, the initial request will be approved for a one-time treatment.

Other Criteria
 	
Review/Revision Date: 8/2026
	****Drug is being requested through the member's medical benefit****
	
	• Patient has one of the following:
	  ○ A hematologic malignancy planned for umbilical cord blood transplantation (UCBT) following myeloablative conditioning
	  ○ Diagnosis of severe aplastic anemia (SAA) as evidenced by bone marrow cellularity < 30% (excluding lymphocytes) AND at least two of the following:
	  ▪ Absolute neutrophil count (ANC) < 500 cells/μL
	  ▪ Platelet count < 20,000/μL
	  ▪ Reticulocyte count < 60,000/μL
	• Prescriber attests that the patient is eligible for myeloablative allogeneic hematopoietic stem cell transplantation (HSCT) AND does not have a readily available matched related donor, matched unrelated donor, mismatched unrelated donor, or haploidentical donor
	• Patient has not received a prior allogenic HSCT
	• Patient does not have known allergy to dimethyl sulfoxide (DMSO), Dextran 40, gentamicin, human serum albumin, or bovine material
	• Requests for severe aplastic anemia also require a trial and failure, intolerance, or contraindication to immunosuppressive therapy (i.e., anti-thymocyte globulin [ATG] + cyclosporine, eltrombopag + cyclosporine, etc.)
	
	The safety and effectiveness of repeat administration of Omisirge have not been evaluated and will not be approved.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Oncology Drugs/Therapies**
Drugs	Oncology drugs and Oncology Gene Therapies (specialty or non-specialty) without product-specific criteria when requested for an oncology diagnosis
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert), and/or per the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO).
Exclusion Criteria	N/A
Required Medical Information	See “other criteria”
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a specialist in the type of cancer being treated
Coverage Duration	If the criteria are met, the request will be approved for up to 6 months.

Other Criteria
 	
Revision/
Review Date:
2/2026
	All of the following criteria must be met:
	
	• Requested use must be a labeled indication or supported by NCCN Category 1 or 2A level of evidence. If the request is for an off-label use supported by NCCN as a Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction contraindication)
	• Documentation has been provided of the results of genetic testing where required per drug package insert
	• Documentation has been provided of results of all required laboratory values and patient specific information (e.g. weight, ALT/AST, serum creatinine, absolute neutrophil count etc.) necessary to ensure the patient has no contraindications to therapy product drug package insert
	• The product is being prescribed at a dose that is within labeling and/or NCCN guidelines.
	• If the request is for a brand name drug, the prescriber must provide a medical reason why the generic cannot be used (when a generic is available).
	  ○ If the request is for abiraterone 500 mg tablets, prescriber must submit a medical reason why two tablets of generic abiraterone acetate 250 mg cannot be used
	• If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following:
	  ○ The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested
	  ○ The provider has verbally, or in writing, submitted a member-specific reason why the reference biologic product is required based on the member's condition or treatment history; **AND** if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. MedWatch form must be included with the prior authorization request.
	Form FDA 3500 – Voluntary Reporting
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Opioid-containing Products**
Drugs	Any opioid being filled for a cumulative morphine milligram equivalent (MME) dose of greater than 90 MME per day or any opioid being filled for > 7 days for a member that has not filled an opioid drug in the past 90 days.
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex (DRUGDEX), American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Members taking buprenorphine-containing products for opioid dependence.
Required Medical Information	N/A
Age Restrictions	Per package insert
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request will be approved for up to 6 months.

Other Criteria	***If the member has **cancer**, is on **hospice**, or is a resident of a **long-term care facility**, the criteria below do not apply. Please authorize for up to 12 months (member must meet non-formulary criteria if request is for non-formulary medication)*** <u>Initial authorization for opioid-containing products:</u> 1. The diagnosis is pain. For long-acting products, the diagnosis is chronic pain that requires daily, around the clock, opioid medication. 2. The member has tried and failed non-pharmacologic treatment and two non-opioid containing pain medications (ex. acetaminophen, non-steroidal anti- inflammatory drugs (NSAIDs), select antidepressants, anticonvulsants). 3. The prescriber has justified medical necessity for dosing above 90 MME per day and/or above the day supply limit. 4. Member is not taking a benzodiazepine. If member is taking a benzodiazepine, prescriber has provided documentation as to why and has discussed risks of using opioids and benzodiazepines together. 5. Prescriber attests that urine drug screens will be completed every 6 months and if illicit drugs are found, the member will be identified as high risk and the heightened risk of overdose will be explained to the member. 6. Prescriber attests to checking the Minnesota Prescription Monitoring Program (PMP) for member history. 7. Prescriber attests to discussing with the member the level of risk for opioid abuse/overdose with the dose/duration prescribed. 8. If member has a high-risk condition stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, renal or hepatic insufficiency, older adults, pregnant women, depression or other mental health conditions, alcohol or other substance use disorders) prescriber attests to discussing heightened risks of opioid use and has educated the member on naloxone use and has considered prescribing naloxone. 9. Prescriber attests that the member has entered into a pain management agreement (members in a facility are exempt from this requirement). 10. If the request is for a non-formulary opioid, member must meet the criteria above AND documented trial and failure or intolerance with at least 2 formulary medications used to treat the diagnosis. <u>Reauthorization for opioid-containing products:</u> 1. The member's dose has been tapered down since the initial authorization. If it has not, the prescriber has explained medical necessity for continued dosing above 90 MME per day and/or above the day supply limit and has provided a proposed plan for tapering the dose down in the future. 2. The provider has submitted documentation of member's response to the requested medication (ex. improvement in pain severity, improvement in ADL's, etc.) 3. Member is not taking concurrent benzodiazepines. If member requires benzodiazepines, prescriber has provided documentation as to why and has discussed risks of using opioids and benzodiazepines together. 4. Urine drug screen has been conducted every 6 months and results have been submitted with the request. If illicit drugs are found, prescriber has explained heightened risk of overdose to member. If opioids are not found on urine drug screen, prescriber has documented why member needs to continue opioid therapy. 5. Prescriber attests to checking the Minnesota Prescription Monitoring Program (PMP) for member history. **If the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.**
Revision/Review Date: 2/2026	

Prior Authorization Group Description	**Oral Retinoids**
Drugs	**Formulary (preferred) products (require PA):** • Claravis (isotretinoin) • Zenatane (isotretinoin) • Amnesteem (isotretinoin) • Isotretinoin **Non-formulary (non-preferred) products:** • Absorica, Absorica LD (isotretinoin) • Accutane (isotretinoin) • Or any newly marketed oral retinoid product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request will be approved for 6 months.
Other Criteria	**Initial Authorization** • Diagnosis of moderate to severe recalcitrant nodular acne • Documented treatment with a therapeutic trial and failure, intolerance to, or medical reason for not using, one or more first line topical therapies (e.g. topical antibiotics, benzoyl peroxide, or topical retinoids) IN COMBINATION WITH one or more first line oral antibiotic therapies (e.g. doxycycline, minocycline, sarecycline, erythromycin) for at least 28 days of therapy in the previous 60 days. • Dose is appropriate for member • If the request is for a brand product, documented trial and failure or intolerance to a generic product is required. • If the request is for a non-preferred drug, documentation has been provided that the member has tried and failed two preferred drugs or has a medical reason why these drugs cannot be used **Reauthorization** • Documentation that the member has experienced clinical benefit from therapy and continue treatment, or retreatment, with isotretinoin is necessary
Revision/Review Date: 8/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Oxervate**
Drugs	Oxervate (cenegermin-bkbj)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist or optometrist
Coverage Duration	If all of the criteria are met, the request will be approved for a one-time 8-week treatment course. Additional treatment beyond 8-weeks will not be authorized.
Other Criteria Revision/Review Date 2/2026	1. Documented diagnosis of Stage 2 or 3 neurotrophic keratitis 2. Documented treatment failure with at least one conventional non-surgical treatment for neurotrophic keratitis (i.e., artificial tear products, therapeutic soft contact lenses) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Palynziq (pegvaliase-pqpz)**
Drugs	Palynziq (pegvaliase-pqpz)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "other criteria"
Age Restrictions	Per package insert
Prescriber Restrictions	Specialist experienced in the treatment of phenylketonuria (PKU)
Coverage Duration	Initial authorization: 12 months Dose increases (to 40 mg or 60 mg daily): 16 weeks Reauthorization: 12 months
Other Criteria Revision/Review Date: 8/2026	INITIAL AUTHORIZATION: • Documentation of a confirmed diagnosis of phenylketonuria (PKU) • Documentation the member's blood Phe level is greater than 600 micromol/L(include lab results; must be within the past 90 days) • Documentation consistent with order forms or receipts that the member has attempted control of PKU through a Phe-restricted diet with Phe-free medical products/foods in conjunction with a dietician or nutritionist. (e.g. Phenyl-Free (phenylalanine free diet powder), Loplex, Periflex, Phlex-10, PKU 2, PKU 3, XPhe Maxamaid, XPhe Maxamum,) • Member has trialed therapy with sapropterin (Kuvan) and either had an inadequate response, was a non-responder, or has a medical reason they cannot trial sapropterin (Kuvan). • The medication is being prescribed at a dose no greater than the FDA approved maximum initial dose of 20 mg SQ once daily. AUTHORIZATION FOR DOSE INCREASE: • Documentation of recent blood Phe level results (within the past 90 days) • The medication is being prescribed at an FDA approved dose • Documentation of one of the following: o Member has maintained a dose of 20 mg daily for at least 24 weeks and did not achieve the desired treatment response o Member has maintained a dose of 40 mg daily for at least 16 weeks and did not achieve the desired treatment response REAUTHORIZATION: • Documentation of recent blood Phe level results (within the previous 90 days). • The medication is being prescribed at an FDA approved dose. • Member has achieved an adequate treatment response as demonstrated by a reduction in phenylalanine level from baseline Clinical reviewer/Medical Director must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Papzimeos**
Drugs	Papzimeos (zopapogene imadenovec)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with a pulmonologist, otolaryngologist, oncologist, or other specialist in the treatment of recurrent respiratory papillomatosis
Coverage Duration	If the criteria are met, the request will be approved for up to a 12-week course of therapy. **Renewal requests or requests for more than a one-time course of therapy will not be approved.**
Other Criteria Revision/Review Date: 11/2025	**Initiation of Therapy:** • Member has a diagnosis of recurrent respiratory papillomatosis • Documentation is provided confirming human papilloma type 6 or 11 • Member has a history of voice or airway symptoms which have required 3 or more clinically indicated interventions (surgical resection or laser ablation of disease) in the previous 12 months **Renewal Requests:** Renewal requests or requests for more than a one-time course of therapy will not be approved. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Pediculicides**
Drugs	**Preferred** • Natroba (BRAND) topical suspension • permethrin cream • piperonyl butoxide/pyrethrins shampoo (OTC) **Non-preferred** • malathion (Ovide) lotion • ivermectin (Sklice) lotion • spinosad topical suspension • Crotan (crotamiton) lotion • Pruradik (crotamiton) lotion • Eurax (crotamiton) lotion, cream • or any newly marketed pediculicide
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Appropriate age per package insert
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request will be approved for initial treatment course. For reauthorization, a maximum of 2 treatments in a 30 day period will be approved.

Other Criteria
 	
Revision/Review Date: 8/2026
	Initial Authorization:
	• Diagnosis of pediculosis capitus (head lice and its eggs) or scabies
	• One of the following:
	  o Documented intolerance or hypersensitivity to two preferred agents
	  o Documented trial and failure of at least two preferred agents within the previous 45 days, but no earlier than 7 days after the original fill; or a reason was provided as to why preferred agents cannot be used
	Re - Authorization:
	• Natroba can be approved for a second treatment if live lice are present 7 days after the initial treatment.
	• Malathion (Ovide) can be approved for a second treatment if live lice are present 7-9 days after the initial treatment.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group	**Phenylalanine Hydroxylase Activators**
Drug(s)	sapropterin (Kuvan), Sephience (sepiapterin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert).
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	Prescribed by specialist experienced in treating PKU
Coverage Duration	Initial: If the criteria are met, the request will be approved for 2 months. Reauthorization: If the criteria are met, the request will be approved for 3 months.
Other Criteria Revision/Review Date: 11/2025	**INITIAL AUTHORIZATION:** • Documentation of the member's current weight • Documentation of a confirmed diagnosis of phenylketonuria (PKU) • Documentation of the patient's baseline blood Phe level (within 30 days of the request) • Documentation consistent with order forms, receipts, or chart notes (within 30 days of request) that the patient is currently utilizing a Phe restricted diet • For Sephience: Documented trial and failure, intolerance, or contraindication to sapropterin in combination with Phe- restricted diet • The medication is being prescribed at the FDA-approved dose **REAUTHORIZATION:** • Documentation of the member's current weight • Documentation of one of the following: o Decrease in Phe level from baseline OR o Increase in dietary Phe tolerance or improvement in clinical symptoms • The medication is being prescribed at the maximum FDA-approved dose **Clinical reviewer/Medical Director must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Proprotein Convertase Subtilisin/kexin 9 (PCSK9) Inhibitors**
Drugs	**PDL Non-Preferred:** • Praluent (alirocumab) • Repatha (evolocumab) • Leqvio (inclisiran)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist or specialist in the treatment of lipid disorders.
Coverage Duration	If the conditions are met, the request will be approved for 3 months for initial requests and for up to 12 months for reauthorization requests.

Other Criteria
 	
Revision/Review Date: 11/2025
	<u>Initial Authorization</u>
	
	For all requests:
	• Request is appropriate for member (e.g. age) as indicated in labeling or standard of care guidelines
	• One of the following:
	  o Provider indicates member's LDL-C is above goal OR
	  o Genetic test submitted with request (for diagnosis of familial hypercholesterolemia (FH) only)
	• Member has tried and failed atorvastatin 40-80 mg or rosuvastatin 20-40 mg (taken consistently for 3 months via claim history or chart notes). If patient is not able to tolerate atorvastatin or rosuvastatin, documentation was provided that patient is taking another statin at the highest tolerated dose, or a medical reason was provided why the member is not able to use these therapies.
	  o If prescriber indicates member is "statin intolerant", documentation was provided including description of the side effects, duration of therapy, "wash out", re-trial, and change of agents.
	• Member has tried and failed ezetimibe at a maximal tolerated dose OR one of the following:
	  o Patient has an LDL-C that is >25% above goal LDL-C while adherent to treatment with highest-tolerated intensity statin (if clinically appropriate) consistently for 3 months
	  o Documentation has been provided that the patient is not able to tolerate ezetimibe
	• Documentation was provided indicating provider has counseled member on smoking cessation and following a "heart healthy diet".
	
	<u>Reauthorization for all indications:</u>
	• Repeat fasting lipid panel shows reduction in LDL from baseline (prior to starting PCSK9 inhibitor). The patient's claim history shows consistent therapy (e.g. monthly fills).
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Dendritic Cell Tumor Peptide Immunotherapy**
Drugs	Non-Formulary: Provenge (sipuleucel-T)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Small cell/neuroendocrine prostate cancer
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescribed by an oncologist or urologist
Coverage Duration	If all of the criteria are met, the request will be approved for 3 doses per lifetime

Other Criteria	**Initial Authorization:**
	• Metastatic castrate resistant (hormone-refractory) prostate cancer (mCRPC) (consistent with medical chart history)
	  o Evidenced by soft tissue and/or bony metastases
	  o Member does NOT have
	  ▪ M0CRPC (defined as CRPC whose only evidence of disseminated disease is an elevated serum PSA) is not authorized
	  ▪ Visceral metastases (e.g. liver, lung, adrenal, peritoneal, brain)
	• Member is not currently being treated with systemic immunosuppressants (e.g., chemotherapy, corticosteroids) or, if the member is being treated with immunosuppressants, the prescriber has provided a valid medical reason for combination therapy
	• Eastern Cooperative Oncology Group (ECOG) score 0-1
	• Serum testosterone <50 ng/dL (e.g., castration levels of testosterone)
	• Predicted survival of at least six months
	
	Reauthorization:
	• Treatment exceeding 3 doses per lifetime will not be authorized

Revision/Review Date: 05/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Potassium-Removing Agents**
Drugs	**Veltassa (patiromer), Lokelma (sodium zirconium cyclosilicate)**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	According to the package insert
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, nephrologist or transplant specialist
Coverage Duration	If the criteria are met, the request will be approved with up to a 3 month duration for initial requests and up to 6 months for renewal requests
Other Criteria Revision/Review Date 5/2026	**Initial Authorization** • Diagnosis of hyperkalemia • Documentation patient has been counseled to follow a low potassium diet • Where clinically appropriate, documentation of medications known to cause hyperkalemia (e.g., angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, NSAIDs) have been discontinued or decreased to lowest effective dose **Re-Authorization** • Documentation that demonstrates member is receiving clinical benefit from treatment (e.g., potassium level returned to normal or significant decrease from baseline). **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

<table>
<tr><td>Prior Authorization Group Description</td><td colspan="2">Pulmonary Hypertension (PH) Agents</td></tr>
<tr><td>Drugs</td><td><u>Preferred:</u>
ambrisentan
sildenafil tablets
sildenafil suspension
Tracleer tablets (BRAND)</td><td><u>Non-preferred/Non-Formulary:</u>
Adcirca, Alyq (tadalafil)
Adempas (roiciguat)
bosentan
epoprostenol (Flolan,Veletri)
Letairis (BRAND)
Opsumit (macitentan)
Opsynvi (macitentan and tadalafil)
Orenitram ER (treprostinil)
Yutrepia (treprostinil)
Revatio (sildenafil)
tadalafil
Tracleer (bosentan) suspension
treprostinil (Remodulin)
Tyvaso/Tyvaso DPI (treprostinil)
Tadliq (tadalafil)
Uptravi (selexipag)
Winrevair (sotatercept-csrk)
any other newly marketed PAH treatment</td></tr>
<tr><td>Covered Uses</td><td colspan="2">Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</td></tr>
<tr><td>Exclusion Criteria</td><td colspan="2">N/A</td></tr>
<tr><td>Required Medical Information</td><td colspan="2">“See Other Criteria”</td></tr>
<tr><td>Age Restrictions</td><td colspan="2">According to package insert</td></tr>
<tr><td>Prescriber Restrictions</td><td colspan="2">Prescribed by or in consultation with a pulmonologist or cardiologist</td></tr>
<tr><td>Coverage Duration</td><td colspan="2">Orenitram, Tyvaso, Yutrepia, Adempas: 3 months for initial request
Opsynvi: 4 months for initial request
Uptravi: Request will be approved for the titration pack for 28 days until the highest tolerated dose (maintenance dose) is achieved. Once the member has achieved maintenance dosing, further refills can be approved for a 6 month duration.
For all others, if all of the conditions are met, the request will be approved for a 6 month duration.</td></tr>
<tr><td>Other Criteria</td><td colspan="2"><u>Initial Authorization:</u>
• Member has a confirmed diagnosis that is indicated in the FDA approved package insert or has other medically-accepted use
• If a non-preferred drug is being requested, the member has had a trial of at least two preferred chemically unique drugs within the same drug class, or a trial of at least one preferred drug within the same drug class if there are not two chemically unique preferred drugs within the same drug class; or documentation was provided as to why the member cannot use preferred drugs
• If the request is for Tyvaso, Uptravi, Orenitram, Remodulin, Yutrepia, or Adempas, ONE of the following:</td></tr>
</table>

Revision/Review Date: 5/2026	○ Documented trial and failure of one PDE-5 inhibitor (e.g. sildenafil, tadalafil) AND one Endothelin Receptor Antagonist (bosentan, ambrisentan, or Opsumit) ○ Diagnosis of WHO Group 1 FC III with evidence of rapid disease progression or FC IV (Uptravi, Orenitram, Tyvaso, , Yutrepia, Remodulin ONLY) ○ Diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4 after surgical treatment, or inoperable CTEPH (Adempas ONLY) ○ Diagnosis of PH-ILD WHO Group 3 (Tyvaso ONLY) • If the request is for sildenafil oral suspension, Tracleer (bosentan) tablet for suspension, or Tadliq (tadalafil) oral suspension, documentation has been submitted as to why patient is unable to use the same ingredient in a tablet dosage form (e.g. difficulty swallowing) • If the request is for Opsumit the patient must have a documented trial and failure or intolerance to ambrisentan and bosentan, or provide a medical reason why these therapies are not appropriate • If the request is for Opsyvni, BOTH of the following: ○ Patient has been stable for at least 6 months on combination therapy consisting of a PDE-5 inhibitor AND an ERA ○ Documentation is provided as to why patient is unable to take individual pills for combination therapy (e.g. adherence due to pill burden) • If the request is for Winrevair, ALL of the following: ○ Documented trial and failure of, or contraindication to, combination therapy including one PDE-5 inhibitor AND one ERA OR Opsyvni ○ Documentation of platelet count of $\geq$ 50,000/mm^3 • Documentation of the patient's current weight, dosing, and titration schedule is provided (if applicable) • The medication is prescribed at a dose that is within FDA approved guidelines **<u>Re-authorization:</u>** • Documentation has been submitted indicating the clinical benefit of therapy (e.g., improvement in functional class, improvement in 6-minute walk test, exercise capacity, or hemodynamics). • Documentation of member's current weight, dosing, and titration schedule is provided (if applicable). • The medication is prescribed at a dose that is within FDA approved guidelines. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Pyrimethamine**
Drugs	pyrimethamine (Daraprim)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an appropriate specialist (i.e. infectious disease, OB/GYN).
Coverage Duration	Toxoplasmosis • Primary prophylaxis - 3 months at a time. • Treatment - 6 weeks at a time. • Congenital toxoplasmosis - up to 12 months. • Secondary prophylaxis (i.e., chronic maintenance) - 3 months at a time. • In pregnancy - up to 22 weeks. Cystoisosporiasis • Treatment - 1 month at a time. • Secondary prophylaxis – 3 months at a time. Pneumocystis pneumonia - 3 months at a time.
Other Criteria	**ALL REQUESTS for pyrimethamine should be accompanied by a prescription for leucovorin.** **<u>Toxoplasmosis:</u>** • Primary Prophylaxis: o A medical reason must be provided as to why the patient is not able to use trimethoprim-sulfamethoxazole or atovaquone o For adults with HIV: documentation of CD4 count < 200 cells/µL • Treatment: o Adults and adolescents: must be used in combination with a sulfonamide or clindamycin. o Pediatrics (congenital and acquired): must be used in combination with sulfadiazine • Secondary Prophylaxis (i.e., chronic maintenance treatment) in patient **not** initially treated with a pyrimethamine regimen, a medical reason must be provided as to why the patient is not able to continue with an alternative regimen for maintenance. • Toxoplasmosis in pregnancy: o Must be used in combination with sulfadiazine. o Member must have reached at least 18 weeks gestation. **<u>Cystoisosporiasis:</u>** • Treatment: a medical reason must be provided as to why the patient is not able to be treated with trimethoprim-sulfamethoxazole • Secondary Prophylaxis: o The patient was previously diagnosed with, and completed a

Revision/Review Date: 5/2026	treatment regimen for cystoisosporiasis ○ If patient was not previously treated with a pyrimethamine regimen for the treatment of cystoisosporiasis, a medical reason was provided why the patient is not able to continue the medications used for treatment ○ For adults with HIV: CD4 count ≤200 cells/µL or CD4 count has been > 200 cells/µL for 6 months or less **<u>Pneumocystis Pneumonia:</u>** • Primary Prophylaxis: ○ For adults with HIV: ▪ Documentation of CD4 count < 200 cells/µL or CD4 percentage < 14% or documentation that antiretroviral treatment initiation is delayed ▪ Documentation must be submitted with a medical reason for not utilizing trimethoprim-sulfamethoxazole, dapsone, aerosolized pentamidine, or atovaquone. • Secondary Prophylaxis: ○ For adults with HIV: ▪ The patient was previously diagnosed with, and completed a treatment regimen for pneumocystis pneumonia ▪ If patient was not previously treated with a pyrimethamine regimen, a medical reason was provided why the patient is not able to continue the medications used for treatment. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Pyruvate Kinase Activators**
Drugs	Pyrukynd (mitapivat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Age ≥18 years
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	If the conditions are met, the request will be approved for a 6-month duration for initial requests and a 6-month duration for renewal requests. **If the conditions are not met: may approve up to 14 days of a Pyrukynd Taper Pack to allow for discontinuation tapering
Other Criteria Revision/Review Date: 8/2026	**Initial Authorization:** • The prescribed dose is within FDA approved dosing guidelines • Diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) • Documentation of at least two variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least one is a missense variant • Documentation that the member is **not** homozygous for the R479H variant • Documentation that the member **does not have** two non-missense variants of the PKLR gene, without the presence of another missense variant in the PKLR gene • Documentation of ONE of the following: o The member does not regularly require blood transfusions (defined as requiring less than or equal to 3 red blood cell (RBC) transfusions in the past 52 weeks **and** no transfusions in the past 3 months) AND hemoglobin (Hb) level ≤ 10 g/dL o The member has required more than or equal to 6 RBC transfusions in the past 12 months ▪ Documentation of the number of transfusions and the number of red blood cell (RBC) units transfused • Prescriber attests that the member does not have moderate or severe hepatic dysfunction and will monitor liver function monthly for the first 6 months of treatment • Prescriber attests that the member does not have a history of a prior bone marrow or stem cell transplant • The member is not concurrently using hematopoietic-stimulating agents (e.g. Procrit or Retacrit) • Prescriber attests the member is taking at least 0.8mg of folic acid daily **Reauthorization:**

	• The prescribed dose is within FDA approved dosing guidelines • For the first reauthorization, documentation of benefit: increase in Hb ≥1.5 g/dL over baseline OR a reduction in transfusions, defined as ≥33% reduction in the number of red blood cell (RBC) units transfused over baseline • For subsequent reauthorizations: documentation of benefit: stabilization in Hb levels OR a sustained reduction in transfusions • If the reauthorization criteria are not met, may authorize up to 14 days of a Pyrukynd Taper Pack to allow for tapering. To reduce the risk of acute hemolysis, abrupt discontinuation of Pyrukynd should be avoided. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Qalsody (tofersen)
Drugs	Qalsody (tofersen)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	See "Other Criteria"
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS)
Coverage Duration	If all the criteria are met, initial and reauthorization requests will be approved for 6 months
Other Criteria Review/Revision Date: 8/2026	****Drug is being requested through the member's medical benefit**** **Initial Authorization:** • Diagnosis of ALS • Documentation of genetic test confirming a mutation in the superoxide dismutase 1 (SOD1) gene • Member is not dependent on invasive ventilation or tracheostomy • Documentation of slow vital capacity (SVC) ≥ 50% • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response (e.g., reduction in the mean concentration of neurofilament light [NfL] chains in the plasma, reduction in concentration of SOD1 in cerebrospinal fluid (CSF), or improvement in the Revised ALS Functional Rating Scale (ALSFRS-R) total score) • Member is not dependent on invasive ventilation or tracheostomy • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Reblozyl (luspatercept-aamt)**
Drugs	Reblozyl (luspatercept-aamt) vial for subcutaneous injection
Covered Uses	Medically accepted indications are defined using the following sources: The Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Members are excluded if they have hemoglobin S/beta-thalassemia or isolated alpha-thalassemia.
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Prescriber must be a hematologist or oncologist
Coverage Duration	If all of the criteria is met, requests will be approved for 6 months.

Other Criteria	**Initial Authorization:**
	• Requested dose is appropriate per labeling
	• The member's weight has been provided with the request
	• The member's most recent hemoglobin level (within the last month) has been provided with the request
	• Diagnosis appropriate per Covered Uses
	• For requests for anemia due to beta thalassemia, documentation of all of the following is required:
	  o Member requires regular red blood cell (RBC) transfusions (defined as at least 6 RBC units received over the last 6 months)
	• For requests for anemia due to myelodysplastic syndrome, documentation of all of the following is required:
	  o Myelodysplastic Syndrome Revised International Prognostic Scoring System (IPSS-R) categorization as very low, low, or intermediate risk of progression
	  o Member has required transfusion of 2 or more RBC units within an 8 week period in the last 4 months
	  o Hemoglobin less than 10 g/dl
	
	Reauthorization:
	• For diagnosis of anemia due to beta thalassemia, documentation of both of the following:
	  o Fewer transfusions compared with baseline
	  o A reduction in transfusion requirement of at least 2 RBC units compared with baseline
	• Diagnosis of anemia due to myelodysplastic syndrome: documentation of ONE of the following:
	  o Hemoglobin increase of at least 1.5 g/dl from baseline over a period of 8 to 12 weeks
	  OR
	  o Reduction in RBC transfusion by at least 4 units over an 8 to 12 week period compared with baseline transfusion requirement
	• Prescriber states that the member did not experience a Grade 3 or 4 hypersensitivity reaction

Revision/Review Date: 11/2025	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Retinoic Acid Derivatives**
Drugs	Preferred Agents: (will pay at POS for members ≤ 30 years of age) • adapalene (Differin) 0.1% gel • adapalene (Differin) 0.3% gel • tretinoin 0.025%, 0.05%, 0.1% cream • tretinoin 0.01%, 0.025% gel Non-Preferred Agents • adapalene 0.1% cream • adapalene (Differin) 0.3% gel with pump • tretinoin microspheres (Retin-A Micro) 0.04%, 0.1% gel • tretinoin microspheres (Retin-A Micro) 0.04%, 0.08%, 0.1% gel with pump • Retin-A Micro 0.06%, 0.08% gel with pump • tretinoin (Atralin) 0.05% gel • Aklief (trifarotene) 0.005% cream • Fabior (tazarotene) 0.1% foam • adapalene/benzoyl peroxide (Epiduo) 0.1%-2.5% gel with pump • adapalene/benzoyl peroxide (Epiduo Forte) 0.3%-2.5% gel with pump • clindamycin/tretinoin (Ziana) 1.2%-0.025% gel • tazarotene 0.1% foam • tazarotene 0.1%, 0.05% cream • tazarotene 0.05%, 0.1% gel • Cabtreo (clindamycin, adapalene, benzoyl peroxide) 0.15-3.1-1.2 % gel • Altreno (tretinoin) 0.05% lotion • Arazlo (tazarotene) 0.045% lotion Non-Formulary Agents • adapalene 0.1% lotion • adapalene 0.1% solution • adapalene 0.1% swab • Tazorac (tazarotene) 0.1%, 0.05% cream • Tazorac (tazarotene) 0.1% gel • Differin (adapalene) 0.1% cream • Differin (adapalene) 0.1% gel (OTC) • Differin (adapalene) 0.3% gel, gel with pump • Differin (adapalene) 0.1% lotion • Epiduo Forte (adapalene/benzoyl peroxide) 0.3%-2.5% gel with pump
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Requests for **cosmetic use,** such as fine wrinkles, mottled hyperpigmentation, or facial skin roughness, are excluded from coverage.
Required Medical Information	See “other criteria”
Age Restrictions	Criteria applies to patients over 30 years of age, preferred agents pay for patients 30 and under
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the request will be approved for a maximum of 50 g/30 days for 12 months.

Other Criteria Revision/Review Date: 1/2026	Preferred Agents in members > 30 years of age: • Diagnosis of acne vulgaris or a non-cosmetic, medically-accepted condition Non-Preferred Agents: • Diagnosis of acne vulgaris or non-cosmetic, medically-accepted condition • Documented trial and failure of, or intolerance to, two preferred topical acne medications OR • If the request is for Tazorac for psoriasis, the member has a diagnosis of plaque psoriasis If the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.

Prior Authorization Group Description	**Rezdiffra (resmetirom)**
Drugs	Rezdiffra (resmetirom)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Patients with decompensated cirrhosis ○
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, endocrinologist, or a specialist in the treatment of liver disease.
Coverage Duration	If all of the criteria are met, the requests will be approved for up to a 12 month duration.
Other Criteria Review/Revision Date: 11/2025	**<u>Initial Authorization:</u>** • Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis • Documentation of stage F2 to F3 fibrosis confirmed by biopsy or a noninvasive test (NIT) • Prescriber attestation to providing lifestyle counseling on nutrition and exercise • Prescriber attestation that member avoids excess alcohol intake • The drug is being prescribed at an FDA approved dose according to the member's weight **<u>Re-Authorization:</u>** • The member has clinically benefited from the medication (e.g., the resolution of steatohepatitis and no worsening of liver fibrosis, or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis) • The member continues to have a fibrosis stage of ≤ 3 • The drug is being prescribed at an FDA approved dose according to the member's weight **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Rituximab Agents**
Drugs	Rituxan (rituximab) Rituxan Hycela (rituximab / human hyaluronidase) Truxima (rituximab-abbs) Ruxience (rituximab-pvvr) Riabni (rituximab-arrx)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	See "other criteria"
Prescriber Restrictions	See "other criteria"
Coverage Duration	See "other criteria"
Other Criteria	**Rituximab Will Be Approved if the Following Prior Authorization Criteria is Met** **MULTIPLE SCLEROSIS:** • Refer to the "Healthcare Professional (HCP) administered/IV Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)" policy **NEUORMYELITIS OPTICA SPECTRUM DISORDER (NMOSD):** • Refer to the "Neuormyelitis Optica Spectrum Disorder (NMOSD) Agents" policy **RHEUMATOID ARTHRITIS:** **Initial Authorization:** • The medication is being recommended and prescribed by a rheumatologist. • The member is an adult (≥18 y/o) and has a documented clinical diagnosis of rheumatoid arthritis. • The member has a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (including dates and doses) of 3 months or more of therapy with one conventional (non-biologic) DMARD (e.g. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) or has a documented medical reason (e.g. intolerance, hypersensitivity) for not utilizing these therapies to manage their medical condition. • The member has a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (including dates, doses) of 3 months of more of all preferred biologics indicated for rheumatoid arthritis, or has documented medical reason (intolerance, hypersensitivity, etc.) for not taking ALL of these therapies to manage their medical condition. • Documentation indicating that the member has been screened for hepatitis B virus (HBV) prior to initiation of treatment. • Rituximab is being prescribed at an FDA approved dosage. • If the request if for any medication other than Truxima (rituximab-abbs) there is a

	documented trial and failure of Truxima (rituximab-abbs) or medical reason why (e.g. intolerance, hypersensitivity, contraindication) Truxima (rituximab-abbs) cannot be used If all of the above conditions are met, the request will be approved for up to a 1 month duration. **Reauthorization:** • The member has been receiving rituximab and documentation is provided that a rheumatologist has reevaluated the member and recommends continuation of therapy. • Documentation was provided indicating the member had clinical benefit from receiving rituximab therapy. • At least 16 weeks (4 months) has elapsed since the previous course of rituximab therapy. • Rituximab is being prescribed at an FDA-approved dose. If all of the above conditions are met, the request will be approved for up to a 1 year duration. **PEMPHIGUS VULGARIS** **Initial Authorization:** • The medication is being recommended and prescribed by a rheumatologist or dermatologist • The member is ≥ 18 years with a diagnosis of moderate to severe pemphigus vulgaris • The member is receiving *P. jirovecii pneumonia* (PCP) prophylaxis (e.g. TMP/SMX, dapsone, atovaquone) or the prescriber has provided a medical reason for not prescribing PCP prophylaxis • Documentation indicating that the member has been screened for HBV prior to initiation of treatment was provided with the request • Rituximab is being used in combination with a tapering course of glucocorticoids. • Rituximab is being prescribed at an FDA approved dose/frequency. If all of the above conditions are met, the request will be approved for up to a 1 month duration. **Reauthorization:** • Documentation of clinical benefits (e.g. absence of new lesions) with rituximab therapy was provided by a rheumatologist or dermatologist • The member is receiving PCP prophylaxis (ex. TMP/SMX, dapsone, atovaquone) or the prescriber has provided a medical reason for not prescribing PCP prophylaxis • Rituximab is being prescribed at an FDA approved dose/frequency If all of the above conditions are met, the request will be approved for up to a 12 month duration. **ONCOLOGY INDICATIONS** **Initial Authorization**

	• The medication is being prescribed by an oncologist. • Requested use must be a labeled indication or supported by NCCN Category 1 or 2A level of evidence. If the request is for an off-label use supported by NCCN as a Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication) • The requested indication is CD20 positive • Documentation indicates that the member has been screened for HBV (hepatitis B virus) prior to initiation of treatment. • Rituximab is being prescribed at a dose that is within FDA approved guidelines and/or is supported by the medical compendium as defined by the Social Security Act and/or the National Comprehensive Cancer Network (NCCN) or American Society of Clinical Oncology (ASCO) standard of care guidelines. • If the request is for any medication other than Ruxience (rituximab-pvvr) there is a documented trial and failure of Ruxience (rituximab-pvvr), or medical reason why (e.g. intolerance, hypersensitivity, contraindication) Ruxience (rituximab-pvvr) cannot be used. • If the request is for Rituxan Hycela (rituximab/hyaluronidase human, recombinant), all of the following apply: o The patient has received at least one full dose of a rituximab product by intravenous infusion o The medication is being requested for a malignant condition o A medical reason has been submitted as to why the alternative rituximab product cannot be continued If all of the above conditions are met, the request will be approved for up to 3 months. **Reauthorization:** • The medication is being prescribed by an oncologist. • Rituximab is being prescribed at a dose that is within FDA approved guidelines and/or is supported by the medical compendium as defined by the Social Security Act and/or per the NCCN or ASCO standard of care guidelines. If all of the above conditions are met, the request will be approved for up to 3 months. **GRANULOMATOSIS WITH POLYANGIITIS (GPA) (WEGENER'S GRANULOMATOSIS) AND MICROSCOPIC POLYANGIITIS (MPA):** **Initial Authorization** • The medication is being prescribed by a rheumatologist or nephrologist. • The member is 2 years of age or older and has a documented clinical diagnosis GPA (Wegener's Granulomatosis), EGPA, or MPA AND the prescriber indicates whether this is severe or non-severe disease. • Documentation indicates that rituximab is being used concurrently with glucocorticoids. • Documentation indicates that the member has been screened for HBV prior to initiation of treatment. • Documentation the patient will be receiving PCP prophylaxis (ex. TMP/SMX, dapsone, atovaquone) during treatment or the prescriber has provided a medical

	reason for not prescribing PCP prophylaxis • Rituximab is being prescribed at an FDA-approved dose. • If the patient is 18 years of age or older, and the request is for any medication other than Ruxience (rituximab-pvvr) there is a documented trial and failure of Ruxience (rituximab-pvvr), or medical reason why (e.g. intolerance, hypersensitivity, contraindication) Ruxience (rituximab-pvvr) cannot be used. If all of the above conditions are met, the request will be approved for up to a 1 month duration. **Reauthorization:** • The medication is being recommended and prescribed by a rheumatologist or nephrologist. • Documentation the patient will be receiving *P. jirovecii pneumonia* (PCP) prophylaxis (ex. TMP/SMX, dapsone, atovaquone) during treatment or the prescriber has provided a medical reason for not prescribing PCP prophylaxis • Rituximab is being prescribed at an FDA-approved dose. If all of the above conditions are met, the request will be approved for up to a 12 month duration. **DERMATOMYOSITIS (DM) and POLYMYOSITIS (PM)** **Initial Authorization:** • Rituximab is being recommended and prescribed by a neurologist, rheumatologist, or dermatologist. • Patient meets one of the following: o Bohan and Peter score indicating definite DM or PM o Bohan and Peter score indicating probable DM or PM AND concurring diagnostic evaluation by ≥ 1 specialist (e.g. neurologist, rheumatologist, dermatologist) • Patient does NOT have cancer associated myositis defined as myositis within 2 years of cancer diagnosis (except basal or squamous cell skin cancer or carcinoma in situ of the cervix that has been excised and cured) • One of the following: o Patient has a documented trial and failure of, or has a documented medical reason for not using methotrexate (MTX) OR azathioprine o Patient has severe, life-threatening weakness or dysphagia • Rituximab is prescribed at a dose per the medical compendia (Micromedex, American Hospital Formulary Service (AHFS), DrugPoints, the Drug Package Insert as defined in the Social Security Act and/or per the American Academy of Pediatrics (AAP) standard of care guidelines and has a Class I or IIa recommendation). • If the request is for any medication other than Ruxience (rituximab-pvvr) there is a documented trial and failure of Ruxience (rituximab-pvvr), or medical reason why (e.g. intolerance, hypersensitivity, contraindication) Ruxience (rituximab-pvvr) cannot be used. If all of the above conditions are met, the request will be approved for up to a 1 month duration; **Re-authorization:**

Revision/Review Date: 11/2025	• Rituximab is being recommended and prescribed by a neurologist, rheumatologist, or dermatologist. • Documentation was provided indicating that the patient had clinical benefit from receiving rituximab therapy. • Rituximab is prescribed at a medically accepted dose per the medical compendia. If all of the above conditions are met, the request will be approved for up to a 3 month duration; **OTHER MEDICALLY ACCEPTED INDICATIONS:** **Initial Authorization**: • The medication is being prescribed for a non-FDA approved indication considered to be a medically accepted use of the drug per the medical compendia (Micromedex, American Hospital Formulary Service (AHFS), DrugPoints, the Drug Package Insert) as defined in the Social Security Act or the American Academy of Pediatrics (AAP) standard of care guidelines and has a Class I or IIa recommendation. • The medication being is prescribed at a medically accepted dose per the medical compendia as defined above • The medication is prescribed by a specialist in the field to treat the member's respective medical condition. • Documentation indicates that the member has been screened for HBV prior to initiation of treatment. • Documentation was submitted indicating that the member has a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (including dates, doses of medications) of ALL first line medical therapies as recommended by the medical compendia and standard care guidelines and/or has another documented medical reason (e.g. intolerance, contraindications, etc.) for not receiving or trying all first line medical treatment(s). • If the request is for any medication other than Ruxience (rituximab-pvvr) there is a documented trial and failure of Ruxience (rituximab-pvvr), or medical reason why (e.g. intolerance, hypersensitivity, contraindication) Ruxience (rituximab-pvvr) cannot be used If all of the above conditions are met, the request will be approved for up to a 3 month duration. **Reauthorization:** • The medication is being prescribed at a medically accepted dose per the medical compendia • The medication is prescribed a specialist in the field to treat the member's respective medical condition. • Documentation from medical chart was submitted indicating that the member has experienced a significant clinical benefit from the medication. If all of the above conditions are met, the request will be approved for up to a 3 month duration.

	Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Rhapsido**
Drugs	Rhapsido (remibrutinib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Revision/Review Date: 02/2026	**<u>Initial Authorization:</u>** • Medication is prescribed at an FDA approved dose • Diagnosis of chronic spontaneous urticaria for at least 6 weeks with uncontrolled symptoms • Member has had at least a 2-week trial and failure of, or has a contraindication to, at least two different H1 antihistamines (e.g. cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine) at four times the standard FDA-approved dose • Member has had at least a 2-month trial and failure of, or has a contraindication to, Xolair or Dupixent **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e. change from baseline in weekly itch severity score, etc.) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Rytelo**
Drugs	Rytelo (imetelstat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age and older
Prescriber Restrictions	Prescribed by a hematologist or oncologist
Coverage Duration	If all of the criteria are met, the request will be approved for 6 months.
Other Criteria Review/Revision Date: 08/2026	**Initial Authorization:** • Diagnosis of myelodysplastic syndromes (MDS) with transfusion-dependent anemia • Myelodysplastic Syndrome Revised International Prognostic Scoring System (IPSS-R) categorization as low or intermediate-1 risk of progression • Member has transfusion burden of 4 or more red blood cell (RBC) units within an 8 week period over the last 4 months • Prescriber attestation that complete blood cell count (CBC) will be obtained prior to initiation, weekly for first two cycles, and prior to each cycle thereafter • Member's weight has been provided with request • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of reduction in RBC transfusion burden as compared with baseline • Provider attestation that member is tolerating the medication and is not experiencing any serious adverse reactions • Member's weight has been provided with request • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Self-administered Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)**	
Drugs	**Preferred:** Avonex (interferon beta-1a) Betaseron (interferon beta-1b) Copaxone 20 mg syringe (BRAND) fingolimod Rebif (interferon-beta 1a) teriflunomide dimethyl fumarate (Tecfidera)	**Non-preferred/Non-formulary:** Aubagio (teriflunomide) Copaxone 40 mg syringe Gilenya (fingolimod) glatiramer 20 mg and 40 mg syringe Glatopa 20 mg and 40 mg syringe Extavia (interferon beta-1b) cladribine (Mavenclad) Mayzent (siponimod) Plegridy (peginterferon beta-1a) dimethyl fumarate starter pack (Tecfidera) Vumerity (diroximel fumarate) Zeposia (ozanimod) Bafiertam (monomethyl fumarate) Ponvory (ponesimod) Kesimpta (ofatumumab) Tascenso ODT (fingolimod) or any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.	
Exclusion Criteria	• Primary progressive MS (PPMS) • For Mavenclad: Clinically Isolated Syndrome (CIS)	
Required Medical Information	See “Other Criteria”	
Age Restrictions	Member must be an appropriate age per prescribing information	
Prescriber Restrictions	Prescriber must be a neurologist	
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months for all agents except cladribine (Mavenclad).	

	If all of the criteria for cladribine (Mavenclad) are met, the request will be approved for 1 course at a time with a lifetime maximum of 2 yearly treatment courses [1 course = (1 cycle per 30 days) two times].
Other Criteria	**Initial Authorization:** • Documentation of appropriate indication per drug labeling • For all requests, the medication is being prescribed at a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature • If a non-preferred drug is being requested, the member has had a trial of at least two preferred drugs; or documentation was provided as to why the member cannot use preferred drugs • If the request is for Gilenya (fingolimod), Ponvory (ponesimod), Tascenso ODT (fingolimod), fingolimod or Zeposia (ozanimod): Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination • If the request is for Mayzent (siponimod), documentation of the following is required: o Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination o Results of CYP2C9 genotyping and ▪ patient does not have CYP2C9 *3/*3 (CONTRAINDICATED) ▪ if patient has CYP2C9 *1/*3 or *2/*3, dose does not exceed 1 mg daily • Additionally, if the request is for Tascenso ODT (fingolimod), documentation of member's current weight • If the request is for Kesimpta (ofatumumab), documentation that immunizations are up-to-date. • If the request is for Bafiertam (monomethyl fumarate) or Vumerity (diroximel fumarate), the patient has a trial and failure of or documented medical reason for not using dimethyl fumarate (Tecfidera). • If the request is for cladribine (Mavenclad), documentation of the following is required: o Patient's current weight

Revision/Review Date: 8/2026	○ Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination **Reauthorization Criteria:** • The medication is being prescribed at a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature • Documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit seen) • If the request is for cladribine (Mavenclad) ○ Patient's current weight is documented ○ **NO MORE THAN 2 COURSES IN TOTAL WILL BE APPROVED** • If the diagnosis is clinically isolated syndrome, documentation was provided that the prescriber has reviewed the risks and benefits of continuing DMT versus stopping **<u>Continuation of Therapy:</u>** Members with history of a non-preferred product (within the past 90 days or the past 12 months for cladridine (Mavenclad)) are not required to try a preferred agent prior to receiving the non-preferred product. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Serostim**
Drugs	Serostim (somatropin, mammalian derived)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an HIV or infectious disease specialist
Coverage Duration	If all criteria are met, Serostim will be authorized for 12 weeks.
Other Criteria Revision/Review Date: 8/2026	**Initial Authorization:** • Documented diagnosis of HIV wasting or cachexia • Member has been receiving optimal highly active antiretroviral therapy (HAART) for at least three months prior to initiation of Serostim • Prescriber attests that the member has been evaluated for other possible causes of wasting/cachexia (e.g. malignancies) or fat redistribution (e.g. diabetes mellitus, lipodystrophy, etc.) • Current weight has been submitted (must be within the past 3 months) • Provider attests that member has experienced weight loss of greater than 10% of the member's baseline body weight associated with either chronic diarrhea (two or more loose stools per day for greater than or equal to 1 month) or chronic weakness and fever for greater than or equal to 1 month • Member has attempted a course of three months or longer with one (or has a contraindication to all) of the following agents: megestrol acetate, cyproheptadine, or dronabinol • The request is for an FDA approved/medically accepted dose **Reauthorization:** • The member is receiving concomitant HAART therapy • The prescriber has provided documentation of clinical benefit/response to Serostim • The request is for the FDA approved or medically accepted dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Skyclarys (omaveloxolone)
Drugs	Skyclarys (omaveloxolone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist with expertise in treating patients with Friedreich's Ataxia.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria Revision/Review Date 8/2026	**Initial Authorization:** • Diagnosis of Friedreich's Ataxia, confirmed via genetic testing (must submit documentation) • Modified FARS score ≥20 and ≤80 • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response to Skyclarys therapy (i.e. improvement in symptoms, slowing of disease progression, etc.) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Skysona (elivaldogene autotemcel)
Drugs	Skysona (elivaldogene autotemcel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Cerebral adrenoleukodystrophy secondary to head trauma • Positive for human immunodeficiency virus type 1 or 2
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescriber must be a specialist in the disease being treated.
Coverage Duration	If all the criteria are met, the initial request will be approved for a one-time treatment.

Other Criteria
 	
Revision/Review Date: 02/2026
	Initial Authorization:
	• Member has a diagnosis of early, active cerebral adrenoleukodystrophy (CALD) defined as all of the following:
	  ○ elevated very long chain fatty acid (VLCFA) levels
	  ○ confirmed mutations in the ABCD1 gene
	  ○ asymptomatic or mildly symptomatic (neurologic function score, NFS ≤ 1)
	  ○ Gadolinium enhancement on brain magnetic resonance imaging (MRI) of demyelinating lesions and Loes scores of 0.5-9
	• Member is a male 4-17 years of age
	• Medication is prescribed at an FDA approved dose
	• Member has not had a prior allogeneic hematopoietic stem-cell transplant (HSCT)
	• Member has no HLA-matched allogenic donor for HSCT
	
	Re-Authorization:
	The safety and effectiveness of repeat administration of Skysona have not been evaluated and will not be approved.

Prior Authorization Group Description	**Sleep Disorder Therapy**
Drugs	**Formulary:** modafinil armodafinil **Non-formulary/Non-preferred:** Sunosi (solriamfetol) Wakix (pitolisant) Xyrem (sodium oxybate) sodium oxybate Xywav (calcium, magnesium, potassium, and sodium oxybates)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Xyrem/Xywav/Sodium Oxybate: Succinic semialdehyde dehydrogenase deficiency
Required Medical Information	See "other criteria"
Age Restrictions	Per FDA approved prescribing information
Prescriber Restrictions	See "Other Criteria"
Coverage Duration	If the criteria are met, requests for modafinil, armodafinil, Sunosi, and Wakix will be approved for up to 12 months. Requests for Xyrem/Xywav/sodium oxybate will be approved for up to 3 months.
Other Criteria	**Initial criteria for all requests:** • Medication is being prescribed at an FDA approved or medically accepted dose **<u>Modafinil/armodafinil initial authorization:</u>** • For a diagnosis of obstructive sleep apnea (OSA), documentation that the member has been compliant with or is unable to use positive airway pressure [e.g. continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP), or automatic positive airway pressure (APAP)]. • Diagnosis of cancer-related fatigue, in patients receiving cancer treatment (modafinil only). **<u>Sunosi initial authorization</u>** • Documented trial and failure of, or medical reason for not utilizing, modafinil or armodafinil • For a diagnosis of OSA, documentation that the member has been compliant with or is unable to use positive airway pressure (CPAP, BPAP, APAP). • Medication is not being taken concurrently or within 14 days of an MAOI **<u>Wakix initial authorization:</u>** • For a diagnosis of narcolepsy **without cataplexy**, documented trial and failure of, or medical reason for not utilizing, each of the following: o Modafinil or armodafinil **AND** o Sunosi

Revision/Review Date: 8/2026	**<u>*For members under 18 years of age, no prerequisite medication trials are required*</u>** • For a diagnosis of narcolepsy in members 18 years of age and older **with cataplexy**, documented trial and failure of, or medical reason for not utilizing dextroamphetamine **<u>Sodium Oxybate (Xyrem/Xywav) initial authorization</u>** • Medication is not being taken concurrently with sedative hypnotics • If member has a history of substance abuse, documentation has been provided that prescriber has referred the member for substance abuse disorder treatment. ***For members under 18 years of age, no prerequisite medication trials are required*** • For a diagnosis of narcolepsy in members **18 years of age and older without cataplexy**: o Documented trial and failure of, or medical reason for not utilizing ALL the following: ▪ Modafinil or armodafinil ▪ Sunosi ▪ Wakix o For Xyrem or Xywav: documented trial and failure of, or medical reason for not using generic sodium oxybate • For a diagnosis of narcolepsy in members **18 years of age and older with cataplexy**: o Documented trial and failure of, or medical reason for not utilizing, each of the following: ▪ Dextroamphetamine **AND** ▪ Wakix o For Xyrem or Xywav: documented trial and failure of, or medical reason for not using generic sodium oxybate • For a diagnosis of idiopathic hypersomnia (Xywav only): o Documented trial and failure of, or medical reason for not using one of the following: ▪ modafinil ▪ armodafinil **<u>Reauthorization:</u>** • Documentation has been submitted indicating member has experienced a clinical benefit from treatment (e.g. improvement on Epworth Sleepiness Score, reduced frequency of cataplexy attacks) • For a diagnosis of obstructive sleep apnea (OSA) documentation that the member continues to be compliant with or is unable to use positive airway pressure (CPAP, BPAP, or APAP). **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Somatostatin Analogs and Growth Hormone Receptor Antagonists**
Drugs	Octreotide (Sandostatin) Octreotide (Sandostatin LAR) Lanreotide 120 mg/0.5 mL Lanreotide (Somatuline Depot) 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5mL Mycapssa (octreotide) Signifor (pasireotide) Signifor LAR (pasireotide) Somavert (pegvisomant) Palsonify (paltusoltine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA) Drug Package Insert (PPI). ** Non-FDA approved (i.e. off-label) uses; refer to the "Off-Label Use" policy for non-oncology indications, and the "Oncology Drugs" policy for off-label oncology uses**
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA approved package insert
Prescriber Restrictions	Prescriber must be a specialist with appropriate expertise in treating the condition in question (such as an endocrinologist, neurologist/neurosurgeon, oncologist, etc.). Consultation with appropriate specialist for the condition in question is also acceptable.

Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria	**Initial Authorization**
	
	For all FDA approved indications (including FDA-approved oncology related uses)
	
	• Medication requested is for an FDA approved indication and dose
	• If the provider is requesting therapy with more than one somatostatin analog or a somatostatin analog and a growth hormone receptor antagonist, then documentation must be submitted as to why patient is unable to be treated with monotherapy, or a medical reason was provided why monotherapy is not appropriate.
	
	For Acromegaly
	
	• Patient has had an inadequate response to, or medical reason why, surgical treatment cannot be used.
	• If the patient has mild disease (e.g. mild signs and symptoms of growth hormone excess, modest elevations in IGF-1) there is a documented trial of a dopamine agonist (e.g. bromocriptine mesylate, cabergoline) at a therapeutically appropriate dose or a documented medical reason why a dopamine agonist cannot be used
	• **Additionally for Mycapssa:**
	  o Patient has showed clinical response to and tolerates treatment with octreotide or lanreotide therapy
	  o Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy
	• **Additionally for Somavert:**
	  o Patient has had an inadequate response to therapy with a somatostatin analog, or has a documented medical reason why a somatostatin analog cannot be used
	• **Additionally for Signifor LAR:**
	  o Patient has had an inadequate response to therapy with either lanreotide (Somatuline Depot) or octreotide (Sandostain, Sandostatin LAR), or has a documented

Revision/Review Date 5/2026	medical reason why these somatostatin analogs cannot be used. • **Additionally for Palsonify:** o Patient has had an inadequate response to therapy with an injectable somatostatin analog, or has a documented medical reason why an injectable somatostatin analog cannot be used o Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy o Patient has had an inadequate response to therapy with Mycapssa, or has a documented medical reason why Mycapssa cannot be used. <u>For Cushing's Disease (pasireotide products only)</u> • Patient must have had inadequate response, or medical reason why surgical treatment cannot be used **<u>Reauthorization</u>** • Medication requested is for an FDA approved indication and dose • Documentation has been provided that demonstrates a clinical benefit (e.g. improvement in laboratory values, improvement or stabilization of clinical signs/symptoms, etc.) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**SMN2 Splicing Modifiers for the Treatment of Spinal Muscular Atrophy (SMA)**
Drugs	Evrysdi (risdiplam) Spinraza (nusinersen)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	• For Spinraza: Patient has previously received treatment with Zolgensma or Itvisma • Concomitant use of Evrysdi and Sprinraza
Required Medical Information	For Evrysdi: Patient's body weight
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all of the conditions are met, the request will be approved for 6 months for 5 doses (4 loading doses and 1st maintenance dose) for initial approval, and 12 months for 3 additional maintenance doses for reauthorization requests.
Other Criteria Revision/Review Date: 08/2026	**<u>Initial approval</u>** • Member has a confirmed diagnosis of SMA types I, II or III and the molecular genetic test with mutation analysis was submitted that is positive for the genetic deletion of the exon 7 of the survival motor neuron (SMN1) • For Spinraza: Documentation of genetic testing confirming either two or three copies of the SMN2 gene **OR** four copies of the SMN2 gene with symptomology of SMA • For Evrysdi: Documentation of genetic testing confirming two to four copies of the SMN2 gene • Baseline motor function or motor milestone achievement was • submitted with request [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk, or Revised Upper Limb Module (RULM), or Motor Function Measure 32 (MFM-32)] The request is for an FDA approved dose **<u>Reauthorization</u>** • Documentation of clinical response was submitted with request (e.g. improvement or stabilization in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening, RULM, MFM-32, patient remains permanent ventilation free if no prior ventilator support) • The request is for an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Specialty Biologic Agents**
Drugs	**Preferred (pays at point-of-sale)** Cyltezo (adalimumab-adbm) adalimumab-adbm Enbrel (etanercept) Otezla (apremilast) Infliximab Starjemza (ustekinumab-hmny) Tofacitinib tablet, ER tablet, solution Tyenne (tocilizumab-aazg) Ustekinumab-aauz (unbranded Otulfi) **Non-Preferred (PA required)** Humira (adalimumab) Actemra (tocilizumab) Cimzia (certolizumab) Bimzelx (bimekizumab-bkzx) Kineret (anakinra) Kevzara (sarilumab) Orencia (abatacept) Entyvio (vedolizumab) Cosentyx (secukinumab) Avsola (infliximab-axxq) Remicade (infliximab) Inflectra (infliximab-dyyb) Renflexis (infliximab-abda) Adbry (tralokinumab-ldrm) Ilumya (tildrakizumab-asmn) Spevigo (spesolimab-sbzo) Amjevita (adalimumab) Hadlima (adalimumab) Abrilada (adalimumab) Yusimry (adalimumab) adalimumab-adbm (Quallent manufacturer) Simlandi (adalimumab-ryvk) Zymfentra (infliximab-dyyb) Velsipity (etrasimod) adalimumab-aaty Wezlana (ustekinumab-auub) Otezla XR (apremilast) Selarsdi (adalimumab-aekn) ustekinumab-ttwe Icotyde oral tablet Pyzchiva (ustekinumab-ttwe) Steqeyma (ustekinumab-stba) Yesintek (ustekinumab-kfce) Ilaris (canakinumab) Tremfya (guselkumab) Siliq (brodalumab) Tysabri (natalizumab) Xeljanz XR, Xeljanz solution (tofacitinib) Taltz (ixekizumab) Olumiant (baricitinib) Rinvoq, Rinvoq LQ (upadacitinib) Skyrizi (risankizumab) Simponi (golimumab) Stelara (ustekinumab) Arcalyst (rilonacept) Cibinqo (abrocitinib) Sotyktu (deucravacitinib) Hulio (adalimumab) Hyrimoz (adalimumab) Idacio (adalimumab) Yuflyma (adalimumab) adalimumab-fkjp adalimumab-adaz adalimumab-ryvk adalimumab-aacf Omvoh (mirikizumab-mrkz) Tofidence (tocilizumab) Avtozma (tocilizumab-anoh) Adalimumab-bwwd (unbranded Hadlima) Otulfi (ustekinumab-aauz) ustekinumab ustekinumab-aekn Imuldosa (ustekinumab-srlf) Xeljanz (tofacitinib) or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug

	Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines. ** Non-FDA approved (i.e. off-label) uses; refer to the "Off-Label Use" policy**
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a specialist in the field to treat the member's respective medical condition
Coverage Duration	If all of the conditions are met, requests will be approved for 12 months.
Other Criteria Revision/Review Date: 11/2026	• The drug is being requested for an appropriate use (per the references outlined in "Covered Uses") • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • If the request is for a non-preferred agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use **two** preferred chemically unique drugs within the same drug as appropriate based on the diagnosis **Reauthorization:** • Documentation submitted indicates that the member has obtained clinical benefit from the medication. • The drug is being requested for an appropriate use and dose (per the references outlined in "Covered Uses") • Requests for a non-preferred agent with a corresponding preferred biosimilar will require an adequate trial of the biosimilar or a medical reason as to why the member is unable to use the preferred biosimilar **Physician/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Sohonos (palovarotene)
Drugs	Sohonos (palovarotene)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Pregnancy • Use in patients younger than 8 years of age for females and 10 years of age for males
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an orthopedic specialist or provider who specializes in rare connective tissue diseases
Coverage Duration	If all of the criteria are met, the request will be approved for up to 12 months
Other Criteria Review/Revision Date: 11/2025	**<u>Initial Authorization:</u>** • Documented diagnosis of fibrodysplasia ossificans progressiva (FOP) • Documented genetic testing of ACVR1 R206H mutation • Attestation that patient is not pregnant and appropriate contraception methods will be used at least 1 month before treatment, during treatment, and 1 month after the last dose (if applicable) • Documentation of weight for patients younger than 14 years old • Medication is prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • Documentation or provider attestation of clinical benefit (i.e., volume reduction of heterotopic ossification) or worsening (i.e., flare-up presence and/or worsening of flare-ups) • Attestation that patient is not pregnant and appropriate contraception methods will be used at least 1 month before treatment, during treatment, and 1 month after the last dose (if applicable) • Documentation of weight for patients younger than 14 years old • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Spravato**
Drugs	**Spravato** (esketamine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patients must be 18 years age or older
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy the request will be approved for 6 months.

Other Criteria
 	
Revision/Review Date 02/2026
	<u>Initial Authorization:</u>
	• Member has a diagnosis of at least one of the following:
	  o Major depressive disorder with treatment-resistant depression
	  o Major depressive disorder with acute suicidal ideation or behavior
	• Medication is being prescribed at an FDA approved dosage.
	• If Spravato is being requested for a diagnosis of major depressive disorder with treatment-resistant depression (i.e. without suicidal ideation or behavior) the member has either:
	  o Documented trial and failure of two preferred oral antidepressants (e.g.. SSRIs, SNRIs, TCAs) of at least a minimum effective dose for four (4) weeks or longer
	  OR
	  o Medical justification as to why the patient cannot use preferred alternative(s).
	• Requests for a diagnosis of major depressive disorder with acute suicidal ideation or behavior (not required for treatment resistant depression):
	  o Prescriber attests Spravato will be used in conjunction with an oral antidepressant
	
	<u>Re-authorization:</u>
	• Medication is prescribed at an FDA-approved dosage.
	• Medication is being used in conjunction with an oral antidepressant (not required for diagnosis of treatment resistant depression).
	• Documentation was submitted indicating the member has clinically benefited from therapy.
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Tavneos (avacopan)**
Drugs	Tavneos (avacopan)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Not Applicable
Required Medical Information	See "Other Criteria"
Age Restrictions	≥18 years old
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or hematologist
Coverage Duration	If the conditions are met, the request will be approved for a 6-month duration for initial requests and a 12-month duration for renewal requests.
Other Criteria Revision/Review Date: 02/2026	**<u>Initial Authorization:</u>** • Diagnosis of one of the following subtypes of severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) • Prescriber attestation that Tavneos will be prescribed in combination with standard therapy (i.e. rituximab, cyclophosphamide, glucorticoids, etc.) unless there is documented trial and failure, intolerance, inability to use, or contraindication to these therapies • The prescribed dose is within FDA-approved dosing guidelines • Documentation of baseline Birmingham Vasculitis Activity Score (BVAS) score • Prescriber attestation that the patient will have liver function tests before treatment (ALT, AST, alkaline phosphate, and total bilirubin) and every 4 weeks after start of therapy for the first 6 months of treatment • Prescriber attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) infection at baseline **<u>Reauthorization:</u>** • Documentation of remission (BVAS score of 0) OR improvement in BVAS score • Prescriber attestation that patient has no abnormality in liver function tests (abnormality: ALT or AST >3 times the upper limit of normal and bilirubin >2 times the upper limit of normal) • Prescriber attestation that patient has no active HBV infection • The prescribed dose is within FDA approved dosing guidelines **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Tecelra (afamitresgene autoleucel)**
Drugs	Tecelra (afamitresgene autoleucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Homozygous or heterozygous for HLA-A*02:05P
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for a one-time treatment.
Other Criteria Review/Revision Date: 11/2025	**<u>Initial Authorization:</u>** • Diagnosis of unresectable or metastatic synovial sarcoma • Documentation that patient is HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive • Documentation that the tumor expresses the MAGE-A4 antigen • Documentation of treatment with prior chemotherapy • Member must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 • Medication is being prescribed at an FDA approved dose **The safety and effectiveness of repeat administration of Tecelra has not been evaluated and will not be approved.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	Topical mTOR kinase inhibitors
Drugs	Hyftor (sirolimus topical gel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	Member concomitantly taking an oral mTOR inhibitor
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 6 years or older
Prescriber Restrictions	Prescriber must be a dermatologist, neurologist, medical geneticist or other prescriber who specializes in the treatment of genetic or dermatologic disorders.
Coverage Duration	If the criteria are met, requests will be approved with up to a 3 month duration. Thereafter, reauthorization requests will be approved with up to a 6 month duration.
Other Criteria Revision/Review Date 11/2025	**Initial Authorization:** • Member has a confirmed diagnosis of tuberous sclerosis complex (TSC) • Member has at least 3 facial angiofibromas measuring 2 mm or larger in diameter • Documentation of a comprehensive dermatologic evaluation has been provided • Prescriber attests that the member is not a candidate for laser therapy or surgery • Medication is being prescribed at an FDA approved dose **Reauthorization:** • Documentation has been provided indicating that the member has experienced a clinical benefit from treatment (e.g. improvement in size and color of angiofibromas) • Documentation of a comprehensive dermatologic evaluation has been provided • Prescriber attests that the member is not a candidate for laser therapy or surgery • Medication is being prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Transthyretin-mediated Amyloidosis Agents**
Drugs	**Preferred:** Polyneurpathy – Onpattro (patisiran), Amvuttra (vutrisiran), Wainua (eplontersen) Cardiomyopathy –Vyndamax (tafamidis), Attruby (acoramidis) **Non-preferred**: Cardiomyopathy – Amvuttra (vutrisiran) Or any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 18 years of age or older
Prescriber Restrictions	Prescriber must be neurologist, cardiologist, or specialist in the treatment of amyloidosis
Coverage Duration	If all of the criteria are met, the requests will be approved for 6 months.
Other Criteria	**Initial Authorization**: • Regimen does not exceed FDA-approved dose/frequency • Requests for use of multiple agents (different mechanism of action) in this policy for mixed polyneuropathy-cardiomyopathy phenotypes will only be considered if patient meets clinical criteria requirements for each section. **Polyneuropathy-Type** • If the request is for Onpattro, Wainua, or Amvuttra, patient has diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis as evidenced by: o Documented transthyretin variant by genotyping o One of the following: ▪ Patient has baseline polyneuropathy disability (PND) score ≤ IIIb ▪ Patient has a baseline Familial Amyloid Polyneuropathy (FAP) Stage 1 or 2 ▪ Patient has baseline neuropathy impairment (NIS) score ≥ 5 and ≤ 130 o Patient has clinical signs/symptoms of neuropathy • **Cardiomyopathy-Type** • • If the request is for Vyndamax, , Attruby, or Amvuttra: patient has diagnosis of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis as evidenced by all of the following: o Documented transthyretin variant by genotyping or wild-type amyloidosis o Documented amyloid deposit by biopsy or positive technetium 99m pyrophosphate (Tc 99m PYP) cardiac imaging o Patient has New York Heart Association (NYHA) functional class I, II, or III heart failure symptoms.

Revision/Review Date: 05/2026	○ For Amvuttra, patient has contraindication to/or previous trial and failure or continued clinical progression with use of Vyndaqel, Vyndamax or Attruby **Re-authorization (for continuing and new patients to the plan)** : • Patient's regimen does not exceed FDA-approved dose/frequency for the agent • Requests for use of multiple agents (different mechanism of action) in this policy for mixed polyneuropathy-cardiomyopathy phenotypes will only be considered if patient meets clinical criteria requirements for each section. • Documented positive clinical response to therapy from baseline (stabilization/slowing of disease progression, improved neurological impairment, motor functions, improved NIS score, stabilization/reduced rate of decline in 6 minute walk test, etc.) • If the request is for Vyndamax/Attruby/Amvuttra ○ Patient has continued NYHA functional class I, II, or III heart failure symptoms **Continuation of Therapy Provision:** Members with history (within the past 90 days) of a non-formulary product are not required to try a formulary agent prior to receiving the non-formulary product. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**

Prior Authorization Group Description	**Type I Interferon (IFN) Receptor Antagonist**
Drugs	Saphnelo (anifrolumab-fnia)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Severe active central nervous system lupus • Active lupus nephritis
Required Medical Information	See "Other Criteria"
Age Restrictions	≥ 18 years
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months, and the reauthorization request will be approved for 12 months.
Other Criteria Revision/Review Date: 11/2025	**Initial Authorization:** • Diagnosis of active moderate to severe systemic lupus erythematosus (SLE) • Member has tried all of the following (or there is a medical reason they cannot use these therapies) before Saphnelo: o Hydroxychloroquine + Glucocorticoids o One other immunosuppressant (i.e., methotrexate, azathioprine, calcineurin inhibitors, or mycophenolate) o Benlysta (belimumab), if member has autoantibody-positive SLE • Prescriber attests member will not be using Saphnelo concurrently with Benlysta • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e., reduction in signs and symptoms of SLE, fewer flares, reduced oral corticosteroid use, etc.) • Prescriber attests member will not be using Saphnelo concurrently with Benlysta • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Tzield (teplizumab-mzwv)
Drugs	Tzield (teplizumab-mzwv)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Type 2 diabetes (T2D)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	If all the criteria are met, the request will be approved for a **one-time treatment.**

Other Criteria	• Medication is prescribed at an FDA approved dose
	• Diagnosis of stage 2 type 1 diabetes (T1D) confirmed by presence of at least two of the following autoantibodies:
	  o Glutamic acid decarboxylase 65 (GAD) autoantibody
	  o Insulin autoantibody (IAA)
	  o Insulinoma-associated antigen 2 autoantibody (IA-2A)
	  o Zinc transporter 8 autoantibody (ZnT8A)
	  o Islet cell autoantibody (ICA)
	• Abnormal glucose on an oral glucose-tolerance test (or alternative glycemic test if an oral glucose-tolerance test is not available)

Revision/Review Date: 02/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Verquvo**
Drugs	Verquvo (vericiguat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Pregnancy
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 8/2026
	• Medication is prescribed at an FDA approved dose
	• The medication is being used for the treatment of symptomatic chronic heart failure with reduced ejection fraction (less than 45%)
	• Documentation that the patient has had a previous hospitalization for heart failure or has required outpatient IV diuretics
	• Member is currently being prescribed the following treatment regimens, or documentation has been provided that the member is not able to tolerate or has a contraindication these agents:
	  o Angiotensin-converting enzyme (ACE) inhibitor OR angiotensin receptor blocker (ARB) OR angiotensin receptor/neprilysin inhibitor
	  o Mineralocorticoid receptor antagonist (e.g. spironolactone)
	  o Evidence-based beta-blocker (i.e. bisoprolol, carvedilol, metoprolol succinate)
	  o Sodium-glucose cotransporter 2 (SGLT2) inhibitor (e.g., Farxiga, Jardiance)
	• Patient is not concomitantly using a phosphodiesterase-5 (PDE-5) enzyme inhibitor (e.g. sildenafil)
	• Negative pregnancy test (for females of reproductive age; as indicated) within 30 days of request
	• Prescriber attests to discussing with females of reproductive potential the need to use effective forms of contraception during treatment and for one month after stopping treatment
	
	Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Prior Authorization Group Description	**Vimizim (elosulfase alfa)**
Drugs	Vimizim (elosulfase alfa)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Member must be 5 years of age or older
Prescriber Restrictions	Prescriber is, or is collaborating with another provider, who is a specialist in the treatment of Morquio A syndrome or other lysosomal storage disorders.
Coverage Duration	6 months

Other Criteria
 	
Revision/Review Date: 8/2026
	<u>Initial Authorization (new to therapy):</u>
	• Patient has confirmed diagnosis of mucopolysaccharidosis IVA (MPS IVA or Morquio A syndrome) via one of the following:
	  o Genetic testing
	  o Analysis of N-acetylgalactosamine 6-sulfatase (GALNS) activity in leukocytes or fibroblasts
	• Medication is prescribed at an FDA approved dose.
	• Documentation of patient weight
	• Patient must have completed a 6-minute walk test for baseline evaluation (must submit results with request) and be able to walk a minimum of 30 meters at baseline
	
	<u>Re-Authorization:</u>
	• Medication is prescribed at an FDA approved dose.
	• Documentation of patient weight
	• Patient shows signs of improvement from baseline in a 6-minute walk test (must submit results with request)
	
	<u>Re-authorization for members new to the plan previously treated with Vimizim:</u>
	• Patient has confirmed genetic diagnosis of mucopolysaccharidosis IVA (MPS IVA, or Morquio A syndrome) via one of the following:
	  o Genetic testing
	  o Analysis of N-Acetylgalactosamine 6-sulfatase (GALNS) activity in leukocytes or fibroblasts
	• Medication is prescribed at an FDA approved dose.
	• Documentation of patient weight
	• Patient must have completed a 6-minute walk test for baseline evaluation (must submit results with request).
	• If a baseline 6-minute walk test was not completed prior to initiation of Vimizim therapy:
	  o A current test must be completed and patient must be able to walk a minimum of 30 meters (must submit results with request)
	  o Continued authorizations for Vimizim for patients without a completed baseline 6-minute walk test evaluation prior to initiation of therapy must continue to be able to walk a minimum of 30 meters in subsequent evaluations.
	  o If patient is established on Vimizim therapy prior to enrollment on the plan, but is not able to walk a minimum of 30 meters, then medical justification is

	required as to how the patient continues to receive benefit from Vimizim therapy. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Voquezna (vonoprazan)**
Drugs	Voquezna (vonoprazan), Voquezna Dual Pack (vonoprazan; amoxicillin), Voquezna Triple Pack (vonoprazan; amoxicillin; clarithromycin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or other specialist with expertise in the treatment of erosive esophagitis or H. pylori infection
Coverage Duration	If all of the criteria are met, the request will be approved for up to the following: • Healing of erosive esophagitis: Voquezna 20 mg once daily for up to 8 weeks • Maintenance of healed erosive esophagitis: Voquezna 10 mg once daily for up to 6 months • Treatment of H. pylori infection: 14 days • For heartburn associated with non-erosive gastroesophageal reflux disease: Voquezna 10 mg once daily for 4 weeks
Other Criteria	**Initial Authorization:** <u>For erosive esophagitis (healing or maintenance of healed erosive esophagitis):</u> • Member has a diagnosis of endoscopy-confirmed erosive esophagitis (all grades) • Member is H. pylori negative • Member has a trial and failure of treatment with ≥ 8 weeks with two different formulary proton pump inhibitors at optimized dosing (double-dose or twice daily dosing), or a medical reason is provided why this is inappropriate. <u>For the treatment of Helicobacter pylori (H. pylori) infection:</u> • Member has a confirmed H. pylori positive infection, plus one of the following clinical conditions: o dyspepsia lasting at least 2 weeks, functional dyspepsia, recent/new diagnosis of peptic ulcer, or a stable dose of long-term NSAID treatment

	• Member has a trial and failure of a generic, guideline recommended, first-line regimen for H. pylori infection such as bismuth quadruple therapy (PPI + bismuth subcitrate or subsalicylate + tetracycline + metronidazole), or a medical reason is provided why this would be inappropriate. <u>For the relief of heartburn associated with non-erosive gastroesophageal reflux disease:</u> • Member has a diagnosis of symptomatic gastroesophageal reflux disease (GERD) with heartburn as the predominant symptom • Member has a history of heartburn lasting at least 6 months, with symptoms on at least four days per week • Member is H. pylori negative, and endoscopy has confirmed patient has no esophageal erosions • Prescriber attests member has been educated about lifestyle modifications related to GERD management (i.e., avoidance of trigger foods, weight loss in overweight and obese patients, avoiding meals within 2-3 hours of bedtime, tobacco cessation, etc.) • Member has a trial and failure of treatment with ≥ 8 weeks with two different formulary proton pump inhibitors at optimized dosing (double-dose or twice daily dosing), or a medical reason is provided why this is inappropriate. **Re-Authorization:** Use of Voquezna for longer than 8 weeks for healing of erosive esophagitis, longer than 6 months for maintenance of healing in erosive esophagitis, or longer than 4 weeks for heartburn associated with non-erosive gastroesophageal reflux disease will not be approved. Renewal requests for Voquezna for treatment of H. pylori infection will not be approved.
Revision/Review Date: 08/2026	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Veopoz (pozelimab-bbfg)
Drugs	Veopoz (pozelimab-bbfg)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Patients with unresolved Neisseria meningitidis infection • Concurrent use of another complement inhibitor (i.e., Soliris)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a physician with experience in managing complement related disorders (i.e., gastroenterologist, immunologist, cardiologist, etc.)
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Medication is prescribed at an FDA approved dose • Diagnosis of CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease • Documentation of hypoalbuminemia (serum albumin <3.5 g/dL) • Documentation of patient weight **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. symptom improvement, normalization of labs such as serum albumin (3.5-5.5 g/dL) and IgG concentrations, reduced hospitalizations and severe adverse events, increased quality of life, etc.) • Documentation of patient weight • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Revision/Review Date: 11/2025	

Field Name	Field Description
Prior Authorization Group Description	Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors
Drugs	Austedo, Austedo XR (deutetrabenazine) Ingrezza (valbenazine) Tetrabenazine (Xenazine) – Huntington's Disease indication only Any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Concurrent use of monoamine oxidase inhibitors (MAOIs)
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or psychiatrist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months, and the reauthorization request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Dose is within FDA-approved limits • Prescriber attests patient will not be receiving treatment with any other VMAT2 inhibitor **For approval for use in Tardive Dyskinesia (TD):** • Member must have clinical diagnosis of tardive dyskinesia that has persisted for the last 90 days, with documented baseline evaluation (e.g., Abnormal Involuntary Movement Scale (AIMS), Extrapyramidal Symptom Rating Scale (ESRI), Schooler and Kane's Research Diagnoses for Tardive Dyskinesia (RD-TD), the Tardive Dyskinesia Rating Scale (TDRS), the Dyskinesia Identification System-Condensed User Scale (DISCUS), or the Texas Research Institute of Mental Sciences Dyskinesia Rating Scale (TRIMS)) • For members on antipsychotics, the antipsychotic dose(s) must have been stable for a continuous 90 day period at some point prior to the request • Prescriber has attempted at least ONE of the following strategies to manage the patient's condition, or has provided a clinical reason why NONE of the following are possible: o Reducing the dose of the drug responsible for causing dyskinesia o Discontinuing the drug responsible for causing dyskinesia o For members on first generation antipsychotics, switching to a second generation antipsychotic o Trial of tetrabenazine or benzodiazepines • For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND

Revision/Review Date: 11/2025	○ For Austedo, Austedo XR requests: ▪ Prescriber attests patient has no signs of hepatic impairment ▪ For patients at risk for QT prolongation, prescriber attests a baseline ECG has been obtained ○ For Ingrezza requests: ▪ Must be dosed at one capsule per day **For approval for use in chorea associated with Huntington's Disease (HD):** • Patient must have diagnosis of moderate to severe Huntington's with chorea, with documented baseline Total Maximal Chorea (TMC) score provided • For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND ○ For Austedo, Austedo XR requests: ▪ Prescriber attests that patient shows no signs of hepatic impairment ▪ Prescriber attests that patient has had a baseline electrocardiogram (EKG) and is aware of the possible risk of QT prolongation ○ For Ingrezza requests: ▪ Must be dosed at one capsule per day **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (e.g., improvement or stabilization from baseline in average scores on the previously submitted symptom rating scale, decrease in symptoms, etc.) • Patient will not be receiving treatment with any other vesicular monoamine transporter 2 (VMAT2) inhibitor • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Vykat XR (diazoxide choline)**
Drugs	Vykat XR (diazoxide choline)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, psychiatrist, or other physician with expertise in the treatment of Prader-Willi syndrome (PWS)
Coverage Duration	If all of the criteria are met, the initial and reauthorization requests will be approved for 6 months.
Other Criteria Review/Revision Date: 08/2026	**<u>Initial Authorization:</u>** • Medication is prescribed at an FDA approved dose • Documentation of member's body weight • Diagnosis of PWS confirmed by genetic testing (copies of test must be submitted with request) • Documentation member experiences symptoms of hyperphagia related to PWS (e.g. food-seeking behaviors, food aggression, etc.) **<u>Re-Authorization:</u>** • Documentation of positive clinical response in hyperphagic symptoms (i.e. decrease in food-related aggression or food-seeking behavior, etc.) • Medication is prescribed at an FDA approved dose • Documentation of member's body weight **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Weight Loss Agents and Related Conditions (GLP1 agonists)**
Drugs	Preferred: Wegovy (semaglutide) Saxenda (liraglutide) liraglutide Foundayo (orforglipron) Zepbound Auto-Injector (tirzepatide) Non-Preferred: Zepbound Kwikpen (tirzepatide) Saxenda (liraglutide) Any newly approved GLP 1 agonist medication indicated for obesity or weight management
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Concurrent use of any glucagon-like-peptide-1 receptor agonist • Personal or family history of medullary thyroid carcinoma • Multiple Endocrine Neoplasia syndrome type 2
Required Medical Information	See "Other Criteria"
Age Restrictions	Age appropriate per labeling
Prescriber Restrictions	Provider is or prescribed in consultation with: • For MASH: hepatologist, gastroenterologist, endocrinologist, or a specialist in the treatment of liver disease • For obstructive sleep apnea: specialist in the treatment of sleep disorders • For other indications: N/A
Coverage Duration	If the criteria are met, the request will be approved for 6 months for initial requests, and 12 months for renewal requests; if the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.

Other Criteria Revision/Review Date: 11/2026	**<u>Initial Authorization (All Agents):</u>** • Requested dose is appropriate per labeling • Documentation of current weight and body mass index (BMI) • Documentation of counseling regarding lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity) • For requests for non-preferred drugs, a trial and failure of, or documented medical reason for not using, a preferred drug is required **<u>Zepbound Requests:</u>** **For treatment of overweight or obesity** or **moderate to severe obstructive sleep apnea** in adults, the following must be met: • BMI must be one of the following: o BMI of 27 - 29.9 kg/m^2 with one of the following weight-related comorbidities: coronary artery disease, diabetes, hypertension, dyslipidemia, or obstructive sleep apnea o BMI of 30 kg/m^2 or more **<u>Wegovy Requests:</u>** For **risk reduction of major adverse cardiovascular events** in adults with established CV disease, **treatment of overweight** in adults, or for **treatment of obesity** in adults and pediatric patients aged 12 years and older, the following must be met: • BMI must be one of the following: o BMI of 27 - 29.9 kg/m^2 with one of the following weight-related comorbidities: coronary artery disease, diabetes, hypertension, dyslipidemia, or obstructive sleep apnea o BMI of 30 kg/m^2 or more o Pediatric patients must be considered obese per package insert (≥95th percentile standardized for age and sex) For the treatment of **noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)**, with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults, all of the following must be met: • Diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis

	• Documentation of stage F2 to F3 fibrosis confirmed by biopsy or a noninvasive test (NIT) • Prescriber attestation to providing lifestyle counseling on nutrition and exercise • Prescriber attestation that member avoids excess alcohol intake **<u>Liraglutide (Saxenda) Requests:</u>** For **treatment of overweight** in adults, or for **treatment obesity** in adults and pediatric patients aged 12 years and older, the following must be met: • BMI must be one of the following: o BMI of 27 - 29.9 kg/m^2 with one of the following weight-related comorbidities: coronary artery disease, diabetes, hypertension, dyslipidemia, or obstructive sleep apnea o BMI of 30 kg/m^2 or more o Pediatric patients must have a body weight greater than 60 kg and be considered obese per package insert (≥95th percentile standardized for age and sex) **<u>Re-Authorization:</u>** For **treatment of overweight or obesity (all agents)**, all of the following must be met: • Documentation of at least 5% reduction in body weight compared with baseline or 5% of baseline BMI for patients with continued growth potential • If a weight-related comorbidity was previously noted, an objective improvement is documented (e.g. reduction in blood pressure, cholesterol, hemoglobin A1c, etc) • Requested dose is appropriate per labeling **Zepbound Requests:** For **treatment of sleep apnea** in adults, all of the following must be met: • Requested dose is appropriate per labeling • Documentation of positive clinical response to therapy (i.e., improvement patient's AHI, improvement in daytime sleepiness, sleep arousals, snoring). • Patient has achieved and/or maintained a 5% decrease in weight since baseline.

	Wegovy Requests: For **risk reduction of major adverse cardiovascular events** in adults with established CV disease, all of the following must be met: • Requested dose is appropriate per labeling For the treatment of **noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)**, with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults, all of the following must be met: • Requested dose is appropriate per labeling • The member continues to have a fibrosis stage of ≤ 3 • Patient is adherent to therapy, as evidenced by claims records demonstrating ≥80% fill rate **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Weight Loss Agents (Non-GLP1 Agonists)**
Drugs	<u>Non-Preferred:</u> Adipex-P (phentermine) phentermine Xenical (orlistat) orlistat amphetamine sulfate tab benzphetamine diethylpropion, diethylpropion ER Evekeo tab phendimetrazine, phendimetrazine ER Lomaira (phentermine) Imcivree (setmelanotide) Any newly-approved non-GLP 1 agonist medication indicated for obesity or weight management *Note: OTC medications for weight loss are excluded from coverage*
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Age appropriate per labeling
Prescriber Restrictions	Imcivree: Prescribed by or in consultation with medical geneticist, endocrinologist, or specialist in metabolic disorders N/A for all other agents
Coverage Duration	If the criteria are met, the request will be approved for 6 months, or 12 months for Imcivree.
Other Criteria	**<u>Initial Authorization:</u>** • Requested dose is appropriate per labeling • Documentation of current weight and body mass index (BMI) • BMI must be one of the following:

Revision/Review Date: 11/2025	○ BMI of 27 - 29.9 kg/m^2 with one of the following weight-related comorbidities: coronary artery disease, diabetes, hypertension, dyslipidemia, or obstructive sleep apnea ○ BMI of 30 kg/m^2 or more ○ Pediatric patients must be considered obese per package insert • Documentation of counseling regarding lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity) • For Lomaira: trial and failure or medical reason for not using generic phentermine • For Imcivree, the patient meets one of the following: ○ Diagnosis of Bardet-Biedl syndrome (BBS) ○ Obesity is related to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency AND: ▪ Deficiency is documented by an FDA-approved genetic test confirming variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance ▪ POMC, PCSK1, or LEPR variants classified as benign or likely benign will not be approved • For requests for non-preferred drugs, a trial and failure of, or documented medical reason for not using, a preferred weight loss drug (e.g. Saxenda, Wegovy) is required (does not apply for Imcivree) **<u>Re-Authorization:</u>** • Documentation of at least 5% reduction in body weight compared with baseline or 5% of baseline BMI for patients with continued growth potential • If a weight-related comorbidity was previously noted, an objective improvement is documented (e.g. reduction in blood pressure, cholesterol, hemoglobin A1c, etc) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**White Blood Cell Stimulators**
Drugs	Preferred: Nypozi (filgrastim-txid) Fulphila (pegfilgrastim-jmdb) Releuko (filgrastim-ayow) Non-Preferred/Non-Formulary: Granix (filgrastim-tbo) Neupogen (filgrastim) Nyvepria (pegfilgrastim-apgf) Neulasta (pegfilgrastim) Neulasta Onpro (pegfilgrastim) Udenyca (pegfilgrastim-cbqv) Leukine (sargramostim) Pplerixafor (Mozobil) Fylnetra (pegfilgrastim-pbbk) Rolvedon (eflapegrastim-xnst) Stimufend (pegfilgrastim-fpgk) Aphexda (motixafortide) Zarxio (filgrastim-sndz) Ziextenzo (pegfilgrastim-bmez) Nivestym (filgrastim-aafi) Udenyca Onbody (pegfilgrastim-cbqv) Ryzneuta (efbemalenograstim alfa-vuxw) and any newly approved product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See “other criteria”
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, organ transplant specialist, or infectious disease specialist.
Coverage Duration	If the criteria are met, the request will be approved for up to 12 weeks. Re-authorization requests for all indications, with the exception of chronic neutropenia, will be approved for 12 weeks. Reauthorization requests for *chronic neutropenia* may be approved for 24 weeks.
Other Criteria	**Criteria for Approval:**

Revision/Review Date: 02/2026	• Drug is being used for an appropriate indication at an appropriate dose per "Covered Uses". • Member's recent (within the last 30 days) ANC (absolute neutrophil count) has been submitted with request • Additional criteria ***for Non-Preferred filgrastim products:*** the member must have a documented treatment failure (e.g. failure to reach and/or maintain target ANC, prolonged febrile neutropenia, or infection requiring prolonged use) with the use of Npozi or Releuko and/or has another documented medical reason (intolerance, hypersensitivity, etc.) for not using Npozi or Releuko. • Additional criteria ***for Non-Preferred PEGfilgrastim or eflapegrastim products:*** the member must have a documented treatment failure (e.g. failure to reach and/or maintain target ANC, prolonged febrile neutropenia, unplanned hospitalization, infection requiring prolonged antimicrobial treatment) which is consistent with pharmacy claims data, with an adequate trial (including dates, doses of therapy) of Fulphila and/or has another documented medical reason (intolerance, hypersensitivity, dose dense chemotherapy, or stem cell collection, etc.) for not using Fulphila to treat the medical condition. o For Neulasta requests, the member must have a documented treatment failure of two biosimilar pegfilgrastim products • Additional criteria ***for Leukine requests:*** Documentation is submitted of the patient's diagnosis, current body weight, and body surface area. • Additional criteria ***for Plerixafor & Aphexda requests:*** Documentation is submitted of the patient's diagnosis and current body weight, and that the patient is using the drug in combination with a granulocyte-colony stimulating factor (G-CSF) agent (e.g. Zarxio, Nivestym). Requests for Aphexda must also have a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia or infection requiring prolonged anti-infection use) with plerixafor **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Xolair for Asthma, Urticaria, and IgE-Mediated Food Allergy**
Drugs	Xolair (omalizumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines.
Exclusion Criteria	• Members actively using another pulmonary biologic (e.g., Cinqair, Fasenra, Nucala, Dupixent, Tezspire) • Use of Xolair concomitantly with Palforzia • Use of Xolair for emergency treatment of allergic reactions, including anaphylaxis
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be an allergist/immunologist, pulmonologist, dermatologist or is working in collaboration with one of these specialists
Coverage Duration	If all of the conditions are met, the request will be approved for up to 6 months.
Other Criteria	****For nasal polyposis, please refer to the "Biologic Agents for Nasal Polyposis" policy**** **Initial Authorization:** **Asthma**: • Member has at least a 6 month history of moderate to severe asthma • The drug is being prescribed at an FDA approved dose according to member's weight and IgE level • Member is taking maximal tolerated dose of inhaled corticosteroid/long-acting beta agonist (ICS/LABA) combination WITH add-on therapy of a LAMA (e.g., tiotropium) for a minimum of 3 months; or there is a documented medical reason why the member is unable to take these medications • Member's asthma is uncontrolled as defined by having at least ONE of the following: o Frequent severe exacerbations requiring two or more bursts of systemic glucocorticoids (more than three days each) in the previous year o History of serious exacerbation: at least one hospitalization, intensive care unit stay, or mechanical ventilation in the previous year o Airflow limitation defined as an FEV1 less than 80% of predicted o Poor symptom control including at least THREE of the following: ▪ Asthma Control Questionnaire (ACQ) consistently >1.5 or Asthma Control Test (ACT) <20 ▪ Daytime asthma symptoms more than twice per week ▪ Use of an inhaled short acting beta2 agonist to relieve asthma symptoms more than twice per week (not including use prior to exercise) ▪ Limited physical activity due to asthma symptoms ▪ Nighttime awakening due to asthma • The member has a positive documented immediate response on RAST test and/or skin prick test to at least 1 common allergen (e.g., dermatophagoides

Revision/Review Date: 05/2026	farinae, dermatop hagoides pteronyssinus, dog, cat, or cockroach) which is an asthma trigger (copy of results required). • Pre-treatment serum IgE levels must be greater than or equal to 30 IU/mL **Chronic Idiopathic Urticaria**: • The drug is being prescribed at an FDA approved dose • The member has a documented history of urticaria for at least 6 weeks • The member remains symptomatic despite a minimum two week trial of a formulary second generation H1 antihistamine at the maximum tolerated dose; or has a medical reason for not utilizing a second generation antihistamine **IgE-Mediated Food Allergy**: • Diagnosis of IgE-mediated food allergy with documented allergy to one or more of the following foods: o Peanut, milk, egg, wheat, cashew, hazelnut, or walnut • Attestation Xolair will be used in conjunction with food allergen avoidance • The drug is being prescribed at an FDA approved dose according to the member's weight and IgE level **Reauthorization:** • Documentation submitted indicates that the member has experienced a clinical benefit from the medication (e.g. decrease in exacerbations, reduction in use of oral steroids, decrease in skin manifestations or severe itching, improvement in pulmonary function tests, etc.) • Request is being prescribed at an approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Xolremdi (mavorixafor)**
Drugs	Xolremdi (mavorixafor)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by an immunologist or a hematologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. If all of the criteria are met, the reauthorization request will be approved for 12 months.
Other Criteria Review/Revision Date: 08/2026	**<u>Initial Authorization:</u>** • Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome confirmed by genotype variant of chemokine receptor 4 (CXCR4) and absolute neutrophil count (ANC) of ≤ 400 cells/μL • Documentation of baseline ANC and absolute lymphocyte count (ALC) • Documentation of member weight • Medication is prescribed at an FDA approved dose **<u>Re-Authorization:</u>** • Documentation or provider attestation of positive clinical response (i.e. improvement from baseline in ANC and/or ALC) • Documentation of member weight • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Yartemlea
Drugs	Yartemlea (narsoplimab-wuug)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Aged 2 years and older
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist or transplant specialist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria	**Initial Authorization:**
	• Member is post-hematopoietic stem cell transplant (HSCT)
	• Member has a confirmed diagnosis of Transplant Associated-Thrombotic Microangiopathy (TA-TMA) based on all of the following:
	  ○ Platelet count < 150,000/µL
	  ○ Evidence of microangiopathic hemolysis (i.e., presence of schistocytes, serum lactate dehydrogenase [LDH] greater than the upper limit of normal [ULN] and/or haptoglobin less than the lower limit of normal [LLN])
	  ○ Renal dysfunction (i.e., doubling of serum creatinine from pretransplant)
	• Member has not received eculizumab therapy within the last three months
	• Member does not have an active infection, including clinically important localized infections

Review/Revision Date: 05/2026	• Member does not have a positive direct Coombs test • Member does not have Shiga Toxin-Producing Escherichia coli Hemolytic Uremic Syndrome (STEC-HUS) • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. improvement in both laboratory TMA markers [lactate dehydrogenase and platelet counts], organ function improvement, no need for transfusions) • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Prior Authorization Group Description	**Yorvipath**
Drugs	Yorvipath (palopegteriparatide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Members with acute postsurgical hypoparathyroidism (HP) or those who are at increased risk for osteosarcoma
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with an endocrinologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For reauthorization, the request will be approved for 12 months.

Other Criteria
 	
Review Date: 02/2026
	Initial Authorization:
	• Confirmed diagnosis of chronic hypoparathyroidism (HP) of postsurgical, autoimmune, genetic, or idiopathic origins, for at least 6 months
	• Provider attestation that member is currently receiving conventional therapy, including active vitamin D (calcitriol) and elemental calcium, and that patient's disease cannot be adequately controlled on conventional therapy alone
	• Current labs (within 60 days of request) have been submitted for the following:
	  o Albumin-corrected serum calcium (must be ≥ 7.8mg/dL to start therapy)
	  o Serum vitamin D level (must be ≥ 20 ng/mL to start therapy)
	• Medication is prescribed at an FDA approved dose
	
	Re-Authorization:
	• Documentation of a recent albumin-corrected serum calcium in the lower-half of the normal reference range or just below the normal reference range (~8–9 mg/dL)
	• Member meets ONE of the following:
	  o Member no longer requires active vitamin D or therapeutic doses of calcium, OR
	  o Member has had a significant reduction in required dosages of active vitamin D or therapeutic doses of calcium and is still actively titrating doses of Yorvipath
	• Medication is prescribed at an FDA approved dose
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Prior Authorization Group Description	**Zevaskyn**
Drugs	Zevaskyn (prademagene zamikeracel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Receipt of any prior chemical or biologic product for the treatment of recessive dystrophic epidermolysis bullosa (RDEB), including Vyjuvek and Filsuvez
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by a specialist experienced in the treatment of epidermolysis bullosa.
Coverage Duration	If all of the criteria are met, the request will be approved for one treatment cycle only.
Other Criteria Revision/Review Date: 08/2026	**Initial Authorization:** • Member has a diagnosis of RDEB with genetic testing confirming mutations in both COL7A1 genes • Presence of RDEB wounds with ALL of the following characteristics: o Open chronically for ≥6 months o Categorized as Stage 2 (partial-thickness) o Have an area of ≥ 20 cm^2 • Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated • Medication is prescribed at an FDA approved dose **The safety and effectiveness of repeat administration of Zevaskyn to the same treatment site have not been evaluated and will not be approved.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	Zinplava (bezlotoxumab)
Drugs	Zinplava (bezlotoxumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for one single dose only.

Other Criteria
 	
Date: 11/2025
	• Patient has a confirmed diagnosis of *Clostridium difficile* infection (CDI)
	• Patient is currently receiving the standard of care antibacterial drugs for CDI (i.e. fidaxomicin, vancomycin)
	• Patient is at high risk of CDI recurrence as defined by at least ONE of the following:
	  o Has a history of CDI within the past 6 months
	  o Is 65 years of age and older
	  o Is immunocompromised
	• Medication is prescribed at an FDA approved dose
	
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Field Name	Field Description
Prior Authorization Group Description	**Zoryve Foam**
Drugs	Zoryve (roflumilast) topical foam
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	If the criteria are met, the request will be approved for up to 12 months.

Other Criteria
 	
Review/Revision Date: 10/2025
	<u>Initial Authorization:</u>
	For the diagnosis of seborrheic dermatitis:
	• Diagnosis of seborrheic dermatitis
	• Documented trial and failure of or intolerance to at least two of the following therapies:
	  o Topical antifungals (i.e., ketoconazole, ciclopirox)
	  o Topical corticosteroids (i.e., betamethasone valerate, clobetasol propionate, fluocinolone)
	For the diagnosis of plaque psoriasis:
	• Diagnosis of plaque psoriasis
	• Documented trial and failure (minimum duration of 4 weeks) of or intolerance to a topical steroid (e.g. betamethasone, clobetasol, fluocinonide, desonide) AND
	• Documented trial and failure of or intolerance to the use of a topical corticosteroid in combination with one of the following topical agents:
	  o Vitamin D analogs (e.g. calcitriol, calcipotriene)
	  o Tazarotene
	  o Calcineurin inhibitors (e.g. tacrolimus, pimecrolimus)
	
	<u>Re-Authorization:</u>
	• Documented positive clinical response to treatment (i.e., improvement in symptoms)
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Prior Authorization Group Description	**Zycubo**
Drugs	Zycubo (copper histidinate)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be less than 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist in the treatment of Menkes disease
Coverage Duration	If all of the criteria are met, the initial request will be approved for up to 6 months and reauthorization will be approved for up to 12 months.
Other Criteria Review/Revision Date: 05/2026	**Initial Authorization:** • Documented diagnosis of Menkes disease confirmed by biochemical or genetic test results • Member has an ATP7A mutation consistent with a severe Menkes disease phenotype • Prescriber attests to obtaining baseline serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count prior to initiation of treatment • Medication is prescribed at an FDA approved dose **Reauthorization:** • Documentation of positive clinical benefit (i.e., improved survival, attainment of developmental milestones, physical gains, normalization of copper-related biomarkers) • Prescriber attests to monitoring serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count as recommended per the manufacturer's prescribing information • Medication is prescribed at an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**